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Supreme Court of the United States

OCTOBER TERM, 1997

DELORES FRAHM, ROYCE TERRY, GERALD COLSON, LAURENCE WILNEFF AND CLAIRE GOLDBERG, ON BEHALF OF A CLASS OF PERSONS SIMILARLY SITUATED,

Petitioners,

v.

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Did the Seventh Circuit err when it held—in conflict with a majority of circuits—that the fiduciary duty of care codified by section 404(a)(1) of the Employee Retirement Income Security Act of 1974 ("ERISA") does not include a duty to convey complete and accurate information about plan benefits, an issue left open expressly by this Court in *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996)?

PARTIES

Petitioners Delores Frahm, Royce Terry, Gerald Colson, Laurence Wilneff, and Claire Goldberg are retirees of respondent Equitable Life Assurance Society of the United States ("Equitable"), and participants in Equitable's United States Employees, Managers and Agents Health Care Plan ("Plan").

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PETITION FOR A WRIT OF CERTIORARI

Delores Frahm, Royce Terry, Gerald Colson, Laurence Wilneff and Claire Goldberg petition for a writ of certiorari to the United States Court of Appeals for the Seventh Circuit to review the decision and judgment in *Frahm v. The Equitable Life Assurance Society of the United States*, 137 F.3d 955 (7th Cir. 1998).

In *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996), this Court reserved "the question [of] whether ERISA fiduciaries have any fiduciary duty to disclose truthful information on their own initiative, or in response to employee inquires" under ERISA § 404(a)(1) (codified at 29 U.S.C. §1104(a)(1)). The Seventh Circuit just answered this question in the negative, holding that a fiduciary bears no responsibility to provide complete and accurate plan information upon inquiry. The respondent Equitable Life Assurance Society of the United States ("Equitable") thereby avoided liability for misrepresentations to its agents about a retiree health plan, which the court found "potentially misleading to someone who had a decision to make" (App. 8). Because the Seventh Circuit's holding conflicts with seven other circuits,[1] is joined only by the

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[1] *Vartanian v. Monsanto Co.*, 131 F.3d 264, 269 (1st Cir. 1997); *Estate of Becker v. Eastman Kodak Co.*, 120 F.3d 5 (2d Cir. 1997); *Shea v. Esensten*, 107 F.3d 625, 628-29 (8th Cir.), *cert. denied*, 118 S. Ct. 738 (1997); *Barker v. American Mobil Power Corp.*, 64 F.3d 1397, 1403 (9th Cir. 1995); *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, 57 F.3d 1255 (3d Cir. 1995), *cert. denied*, 517 U.S. 1103 (1996); *Maez v. Mountain States Telephone and Telegraph, Inc.*, 54 F.3d 1488, 1498-1501 (10th Cir. 1995); *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 751 (D.C. Cir. 1990).

Fourth and Sixth Circuits,[2] and contravenes the purpose and trust law basis of ERISA, petitioners pray that their petition be granted.

OPINIONS BELOW

The Memorandum Opinion and Order of the District Court for the Northern District of Illinois, dated March 25, 1997, entering findings of fact and conclusions of law pursuant to Federal Rule of Civil Procedure 52(a) following a bench trial and granting judgment to Equitable, is unreported and is reprinted herein at App. 14-28. The Opinion of the United States Court of Appeals for the Seventh Circuit, dated February 27, 1998, affirming the district court, is reported at 137 F.3d 955 (7th Cir. 1998) and is reprinted herein at App. 1-13.

JURISDICTION

The opinion of the United States Court of Appeals for the Seventh Circuit was filed on February 27, 1998. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Section 404(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1104(a), is set out at App. 39-40.

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[2] *Sprague v. General Motors Corp.*, 133 F.3d 388, 405-406 (6th Cir. 1998) (*en banc*), *pet. for cert. filed*, Apr. 6, 1998 (No. 97-1639); *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 656-58 (4th Cir. 1996), *cert. denied*, 117 S. Ct. 738 (1997).

STATEMENT OF THE CASE

Petitioners are retired insurance agents formerly employed by Equitable. They allege that Equitable deprived them of health benefits to which they were entitled as early retirees under Equitable's United States Employees, Managers and Agents Health Care Plan ("Plan") (App. 15-16). The Plan provided for continuation of health care coverage for employees who retired from active service before age 65 (id.). Equitable summarized the Plan in a series of Summary Plan Descriptions (or SPDs). These documents stated that Equitable could change or terminate health care benefits at any time (App. 16-18).

On October 15, 1990, Equitable announced that it was amending its health care plan to offer benefits under a program called CHOICE, which would take effect on January 1, 1991 (App. 18). The CHOICE plan, as the district court described, "imposed significantly higher payment obligations on its participants and beneficiaries with respect to premiums, deductibles, co-payments, and maximum out-of-pocket limitations" (App 19). Equitable adopted CHOICE only for its active staff and those who would retire on or after February 1, 1991 (id.). Those retiring before February 1, 1991 would continue to receive health care benefits under the previous Plan (id.). Petitioners Wilneff, Goldberg and Colson retired effective January 1, 1991, one month before the cut-off for CHOICE, while the others retired prior to that date (App. 15). Then, on October 15, 1992, Equitable announced that it would impose CHOICE on all past retirees under age 65, which included petitioners (id.).

Petitioners testified that before retirement Equitable had assured them in various ways that timely, early

retirement would "freeze" or "lock up" the superior benefits of the pre-CHOICE health plan:

- Claire Goldberg, after informing Equitable of her preliminary intention to retire, received a letter dated November 30, 1990 from Equitable benefits consultant Laurie Agin stating that she would "continue to be insured under the current Health Insurance Plan for the remainder of [her] lifetime" (App. 24-25).
- Royce Terry learned prior to retirement from Equitable's president, benefits personnel, and agency managers that he could "lock up" health benefits by working to age 55 (App. 28).
- Laurence Wilneff testified that his agency manager, Jim Schlesinger, told him that "health insurance benefits and premiums would be frozen at the level they were at that particular time" if Wilneff retired at that time (a statement denied by Schlesinger). (App. 21-22).
- Gerald Colson testified that in a December 7, 1990 telephone call with an Equitable benefits advisor, the day after he declared his intention to retire, he received an oral commitment that the Company would "freeze" his benefits under the Plan (App. 22-23).
- Delores Frahm, on January 11, 1989 (after her retirement), received a letter stating that she would continue to be insured under the Plan for the remainder of her lifetime, with her deductible would be frozen at $100 for self-coverage (App. 27).

Following trial, on March 25, 1997, the district court issued an opinion and order finding for Equitable on

petitioners' claims that the company violated ERISA by changing the Plan and requiring additional costs to be shouldered by retirees. In particular, the district court found no breach of fiduciary duty by Equitable for misrepresenting plan terms to the petitioners under ERISA § 404(a)(1). The district court held that Equitable's statements about benefits being "frozen," "lock[ed] up," or "lifetime" did not rise to "affirmative or systematic misrepresentations" and were not calculated to "deliberately deceive[ ] plaintiffs about their health insurance" (App. 37).

The Seventh Circuit affirmed the judgment on February 27, 1998 (App. 1-13). The court conceded that Equitable's descriptions of the retiree's health benefits were "potentially misleading to someone who had a decision to make" and "did not (and could not) provide complete information about what would happen to benefits some years hence" (App. 8). It nonetheless held that the communications did not violate subsection (B) of ERISA § 404(a)(1). The court contrasted the subsection (B) "care, skill, prudence, and diligence" requirement with subsection (A), which "imposes on the plan administrator and other fiduciaries a duty of loyalty, an obligation to act in the participants' interest" (App. 6-7). The Seventh Circuit found that under subsection (A), "an employer may not bilk employees into surrendering their pensions" (App. 6). Yet the court rejected petitioners' contention that ERISA imposes a correlative duty on plan fiduciaries to provide complete and accurate information, on the grounds that it would be too vexing for courts to administer:

> [S]lipups in managing any complex enterprise are inevitable, and negligence—a violation of the duty of care—is not actionable. Quite the contrary, in

> corporate law managers rarely face liability even for gross negligence; if knowing how best to run a firm is a hard task for full-time managers, it is an impossible task for judges, who lack both the expertise and the incentives of managers. (App. 7.)

The Seventh Circuit also believed that a fiduciary duty of disclosure would be superfluous, because the labor market would, given enough time, check dishonesty. "[T]he employer's desire to maintain a reputation for honest dealing with its workers" would encourage good behavior in the long run; "otherwise it will have difficulty attracting and retaining a skilled work force" (App. 13).

REASONS FOR GRANTING THE WRIT

THE MAJORITY OF CIRCUITS, CONTRARY TO THE SEVENTH CIRCUIT'S HOLDING BELOW, APPLY THE COMMON LAW TRUST RULE TO ERISA REQUIRING FIDUCIARIES TO PROVIDE COMPLETE AND ACCURATE INFORMATION TO PARTICIPANTS AND BENEFICIARIES

Under ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B), an ERISA fiduciary must conduct the plan's affairs "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." These fiduciary duties, as Judge Henry Friendly observed, are the "highest known to the law." *Donovan v. Bierwirth*, 680 F.2d 263, 272 n.8 (2d Cir.), *cert. denied*, 459 U.S. 1069 (1982).

The Seventh Circuit, in conflict with seven other circuits, has now turned its back on the duty of due care.

While conceding that Equitable's descriptions of retiree health benefits were "potentially misleading" (App. 8), it found no breach of the duty of care for these misstatements. The court so held based on its legal conclusion that there is no duty of care that attaches to a fiduciary's communications with beneficiaries. Instead, it suggested that the duty of care in ERISA § 404(a)(1) imposes no higher burden on fiduciaries than the "business judgment" rule (*i.e.* "in corporate law managers rarely face liability even for gross negligence") (App. 7). The Seventh Circuit would thus require a finding of deliberate misconduct—a violation of the duty of loyalty—under subsection (A) to impose fiduciary liability, and find no cause of action at all under subsection (B). Under this holding, any costs for negligent misstatements are apparently to be borne by the hapless participant or beneficiary, not the fiduciary who was charged with carefully telling the truth. Because the Seventh Circuit's decision presents a question previously reserved by the Court in *Varity,* is contrary to holdings of seven other circuits, and is in tension with this Court's previous interpretations of the fiduciary provisions of ERISA, the Court should grant writ of certiorari and reverse the decision below.

This Court in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), reserved the question of whether ERISA imposes a duty on fiduciaries to disclose complete and accurate information about benefits. There, Varity's management (acting in a fiduciary capacity) represented to its employees that its new subsidiary—Massey Combines—had a rosy financial future and encouraged incumbent employees to transfer to work there. The parent, it turned out, knew better: the subsidiary was thinly capitalized and built to

fail as a stratagem to eradicate Varity's liabilities, including benefit obligations to its workforce. Yet in communications with employees, the company reported that employees' benefits would remain secure if they voluntarily transferred to the subsidiary. Fifteen hundred employees accepted the invitation to transfer and, within two years, lost their benefits when Massey Combines fell into receivership. The Court found that Varity's statements about the safety of its employees' benefits violated the company's fiduciary duty under ERISA § 404. It based its decision not on the duty of care, but on the duty of loyalty under subsection (A) of section 404(a)(1). *Id.* at 506-07. The Court left for another day "the question [of] whether ERISA fiduciaries have any fiduciary duty to disclose truthful information on their own initiative, or in response to employee inquires." *Id.* at 506.

The facts of the present case rejoin the question left open in *Varity*. Plaintiffs were told variously that their retirement health benefits would be "lock[ed] up," "frozen," or paid for the employee's "lifetime" if they left before February 1, 1991. This, as we know, turned out not to be true. The Seventh Circuit consigned this case to the category of "slipups." Yet what we see here is not just a misplaced decimal point or an isolated mistake. Rather, a wide range of responsible individuals at Equitable acting as fiduciaries[3]—from the president on down—said in concert that petitioners' health benefits would not change after retirement, when the truthful answer would

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[3] *See Varity*, 516 U.S. at 504-05 (employer-fiduciary that makes representations about the future of plan benefits acting as a fiduciary).

have been that no one knew whether they would change or not. Plaintiffs should have been informed more forthrightly about the risks of accepting early retirement. At a minimum, Equitable was heedless of the consequences such representations would have on persons at retirement age who were making decisions about their future.

Most circuits confronting this question left open in *Varity* have found a fiduciary duty of care to provide complete and accurate information under ERISA § 404(a)(1). A notable instance is the Third Circuit's decision in *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, 57 F.3d 1255 (3d Cir. 1995), *cert. denied*, 517 U.S. 1103 (1996). There, as here, the employer-fiduciary issued summary plan descriptions for a medical benefit plan that expressly reserved the right of the employer to terminate the plan "at any time" and for "any reason." Despite these reservations of rights, the company informed employees in separate oral and written communications that upon retirement, medical benefits would "be continued for the rest of your life." The court held that the promises of lifetime benefits violated the "employer's duty, as an ERISA fiduciary, not to misinform employees through material misrepresentations and incomplete, inconsistent or contradictory disclosures." *Id.* at 1264.[4]

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[4] *See also Ream v. Frey*, 107 F.3d 147, 155-56 (3d Cir. 1997) (plan trustee breached fiduciary duty by failing to inform beneficiary of its intent to resign as trustee and appoint a successor); *Glaziers and Glassworkers Union Local No. 252 v. Newbridge Securities, Inc.*, 93 F.3d 1171, 1180-81 (3d Cir. 1996) (criticizing brokerage house that "sat silently by knowing that the [plaintiffs] were placing their assets under" control of

(continued...)

More recently, the Second Circuit imposed the same duty in *Estate of Becker v. Eastman Kodak Co.*, 120 F.3d 5 (2d Cir. 1997) against a company that misinformed an employee about her benefits. The plaintiff, a widower, was a beneficiary of a retirement plan in which his wife was enrolled. Neither the summary plan description nor the oral information provided by a company benefits counselor informed the family that they would forfeit the benefits if the wife died before the effective date of her retirement. Because she was unaware of this fact, the wife (who by this time knew she was terminally ill) did not take other plan options available to her to safeguard her benefits. The court, with no finding of intentional or fraudulent misconduct, held that the company's failure to inform the family in response to inquiries about a material term of the retirement plan violated the fiduciary duty to provide complete and accurate information. Accordingly, the Second Circuit directed a finding in favor of the family on the breach of duty claim. *Id.* at 9-10. *See also Ballone v. Eastman Kodak Co.*, 109 F.3d 117, 122-26 (2d Cir. 1997) (holding that fiduciary could be held liable for untrue assurances about future intention not to provide pension enhancements).

Five other circuits hold that ERISA requires complete and accurate disclosures by fiduciaries. *See Vartanian v.*

— (...continued)
unfaithful trustee); *Bixler v. Central Pennsylvania Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1302 (3d Cir. 1993) (finding actionable, as breach of fiduciary duty, employer's failure to advise widow of plan participant of all available benefits).

Monsanto Co., 131 F.3d 264, 269 (1st Cir. 1997) (examining when employer has duty, as fiduciary, to disclose existence of severance plan proposal); *Shea v. Esensten*, 107 F.3d 625, 628-29 (8th Cir.) (fiduciary's failure to disclose, under HMO policy, that doctors had financial incentive not to make referrals to specialists violated the fiduciary's duty "to deal fairly and honestly" with all plan members), *cert. denied*, 118 S. Ct. 738 (1997); *Barker v. American Mobil Power Corp.*, 64 F.3d 1397, 1403 (9th Cir. 1995) ("[a] fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even when a beneficiary has not specifically asked for the information"); *Maez v. Mountain States Telephone and Telegraph, Inc.*, 54 F.3d 1488, 1498-1501 (10th Cir. 1995) (finding fiduciary duty to disclose); *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 751 (D.C. Cir. 1990) ("[t]his duty to communicate complete and correct material information about a beneficiary's status and options is not a novel idea").

Two other circuits besides the Seventh—the Fourth and Sixth Circuits—reject a duty of truthful disclosure. In *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 656-58 (4th Cir. 1996), *cert. denied*, 117 S. Ct. 738 (1997), over a dissent by Judge Michael, the court held that ERISA § 404 did not require disclosure of information other than specifically required elsewhere in ERISA's reporting section, § 104(b)(4) (29 U.S.C. § 1024(b)(4)). The court distinguished cases from other circuits by asserting that they involved attempts by fiduciaries to "mislead participants or beneficiaries," but that aside from such an extreme case, no court actually "recognize[d] a general fiduciary obligation under ERISA to provide information related to

the plan on request." *Id.* at 657. In *Sprague v. General Motors Corp.*, 133 F.3d 388, 405-406 (6th Cir. 1998) (*en banc*), *pet. for cert. filed* (U.S. Apr. 6, 1998) (No. 97-1639), a majority of the Sixth Circuit sitting *en banc* cited and adopted the Fourth Circuit's analysis in *Faircloth* to reverse a finding by the district court of a breach of fiduciary duty to inform beneficiaries of the prospect that the retiree health plan might be amended or terminated. The majority held that the fiduciary duty extended at most to prohibit "deliberate misleading of employees." *Id.* at 405. Dissenting judges in *Sprague*, as in *Faircloth*, disapproved of this shrunken duty of disclosure. *Id.* at 408 (Lively, J., concurring in part and dissenting in part); *id.* at 415 (Boyce F. Martin, Jr., C.J., and Moore and Cole, J.J., dissenting).

In addition to presenting a circuit conflict, this case raises an important federal question deserving review by this Court, because the minority circuits have adopted a crabbed analysis of ERISA that conflicts with relevant decisions of this Court. As this Court has repeatedly observed, Congress directed the courts under ERISA to look to the common law of trusts to define the fiduciary duties of persons responsible for administering a plan. *Varity Corp.*, 516 U.S. at 496 ("we recognize that these fiduciary duties draw much of their content from the common law of trusts, the law that governed most benefit plans before ERISA's enactment"); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) ("ERISA legislative history confirms that the Act's fiduciary responsibility provisions . . . 'codif[y] and mak[e] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law of trusts'") (quoting H.R. Rep. No. 93-

533, p. 11 (1973), U.S. Code Cong. & Admin. News 1974, pp. 4639, 4649); *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport Inc.*, 472 U.S. 559, 570 (1985) ("rather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility"). While this Court has never demanded slavish adherence to pre-ERISA trust law, *Varity*, 516 U.S. at 497, it has placed the burden on those who would depart from that body of law altogether. *NLRB v. Amex Coal Co.*, 453 U.S. 322, 329 (1981) ("[w]here Congress uses terms that have accumulated settled meaning under either equity of the common law, a court must infer, unless the statute otherwise dictates, that Congress means to incorporate the established meaning of these terms"). The Seventh Circuit fails to justify its departure from established trust law standards.

Trust principles require that when a beneficiary inquires about a trust, the fiduciary must furnish complete and accurate information. *See* Restatement (Second) of Trusts § 173 ("[t]he trustee is under a duty to the beneficiary to give him upon his request at reasonable times complete and accurate information as to the nature and amount of the trust property . . . ."); George Gleason Bogert and George Taylor Bogert, *The Law of Trusts and Trustees* § 961, at 4 (Rev. 2d ed. 1983) ("[i]f the beneficiary asks for relevant information about the terms of the trust, its present status, past acts of management, the intent of the trustee as to future administration, or other incidents of the administration of the trust, . . . it is the duty of the trustee to give the beneficiary the information

which he has asked"); 2A Austin Wakeman Scott and William Franklin Fratcher, *The Law of Trusts* § 173, at 462 (4th ed. 1988) ("[t]he trustee is under a duty to the beneficiaries to give them on their request at reasonable times complete and accurate information as to the administration of the trust"). Even supposing that ERISA had never been passed into law, and the petitioners had proceeded under Illinois trust law, the common law would have imposed liability for incomplete or inaccurate disclosure. *See Williams v. Independence Bank of Chicago,* 201 Ill. App. 3d 685, 690, 559 N.E.2d 201, 205 (1st Dist. 1990) (applying fiduciary "duty to notify"); *In re Estate of Halas*, 209 Ill. App. 3d 333, 348, 568 N.E.2d 170, 180 (1st Dist. 1991) ("[i]t is well established that a trustee owes a duty of full disclosure to the beneficiaries").

Application of this common law rule to ERISA complements the wide powers that the act confers on fiduciaries to administer plans. Early in the history of ERISA, employers acting as fiduciaries pressed courts to apply common law trust doctrines that afforded them maximum discretion in plan administration. *Firestone Tire & Rubber Co.*, 489 U.S. at 112 ("Firestone argues that as a matter of trust law the interpretation of the terms of a plan is an inherently discretionary function"). The Court affirmed such discretion as a practical matter when it held that a denial of benefits would be reviewed by an arbitrary and capricious standard if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. Having won that standard, employers should also be required to live up to conventional fiduciary trust standards. The Court must take care not to

knock out the props—the twin duties of loyalty and care—erected by the common law and expressly incorporated into ERISA by subsections (A) and (B) of section 404(a)(1) to keep trustees faithful and diligent. *See Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 143 n.10 (1985) (recognizing both a duty of loyalty and due care under ERISA).

Moreover, the overall design of ERISA favors maximum flexibility by plan settlors and administrators in exchange for a duty to disclose. ERISA prescribes very little in the way of mandatory provisions for welfare benefit plans. At the same time, Title I of ERISA devotes considerable attention to the fiduciary's duty to inform participants about plan terms. *See, e.g.*, ERISA §§ 101 (duty of disclosure and reporting), 102 (summary plan descriptions), 104(b) (summary plan descriptions), 105(a) (statement of benefits) (29 U.S.C. §§ 1021, 1022, 1024(b), 1025(a)). It would be anomalous, after Congress placed so much emphasis on full disclosure, to allow plan managers to drain the meaning from these requirements through capricious misstatements and misrepresentations. There is therefore no inconsistency (as the Seventh Circuit suggests at App. 9) between ERISA's preference for written plans and a duty by fiduciaries to interpret and describe plan instruments carefully and truthfully.

So why did the Seventh Circuit depart from the well-hewn common law standard? First, it expressed concern that a duty to disclose would be unmanageable. "[S]lipups in managing any complex enterprise are inevitable," the Seventh Circuit wrote (App. 7), implying that fiduciaries should not be held accountable for inevitable lapses in judgment. Yet we tolerate such deference in the arena of

business judgment for a reason: to unfetter management in day-to-day business affairs and to encourage a degree of risk-taking. *Kamen v. Kemper Financial Services, Inc.*, 500 U.S. 90, 101 (1991) (noting deferential "business judgment" rule); 3A W. Fletcher, *Cyclopedia of the Law of Private Corporation* § 1037 (J. Solheim & K. Elkins rev. ed. 1994) (discussing policy justifications for the rule). The Seventh Circuit suggests no comparable reason to lift the customary duty of due care owed by fiduciaries under trust law. If anything, the likely result of the Seventh Circuit's holding is a diminished incentive to police plan administration practices, because the cost of fiduciary carelessness is borne entirely by the participants and beneficiaries at the receiving end of the plan managers' misstatements.

Second, the Seventh Circuit believed that *Varity* hemmed the fiduciary duty into a limited requirement that fiduciaries not "bilk" or "bamboozle" employees into surrendering their pensions (App. 6). "Unlike *Varity*," the Seventh Circuit held, "the Equitable did not undertake a campaign of disinformation that led employees to surrender their benefits" (id.). But if all that ERISA provides employees is a prohibition against deceit, then it left them worse off than under pre-ERISA law, which (as noted) barred not only out-and-out fraud, but also required truthful, complete and accurate disclosures by fiduciaries. Managers who craft and disseminate fiduciary communications about ERISA benefits, and who are in the best position to detect and prevent errors, must be given a legal spur to perform these duties in the best interests of the employees just as they were under the common law.

Finally, the Seventh Circuit argued that a duty of due care is unnecessary, because the employer's "desire to maintain a reputation for honest dealing with its workers" would encourage good behavior (App. 13). This policy argument for rejecting a duty of care under the facts of this case should be rejected. First, the Seventh Circuit offers no empirical support for this argument or any estimate for how long it would take to achieve equilibrium in the market. Second, this long-run, idealized perspective—even assuming its validity in an imperfect world—does nothing for retirees who are the victims of ERISA violations today. Third, this rationalization disregards that public corporations must also answer to their stockholders, who in general favor austerity and cutting costs. Corporations will not invariably privilege candor with employees over their relationships with investors.

Ironically, in devaluing the duty of due care, the Seventh Circuit reversed the normal priorities under ERISA and fashioned a rule to prevent fraud or negligence by *participants*, as if *this* was the greatest problem facing ERISA plans. *See* App. 9 ("Memory is weak compared to the written word, and there is a substantial risk that participants will not correctly recall what was said, will exaggerate (in their favor) what they heard, or will simply prevaricate in order to improve their position"). But Congress—following and incorporating the common law—decreed through ERISA that participants, and not their fiduciaries, foremost deserve the law's protection. The Seventh Circuit's decision is so greatly at odds with the language, history and design of ERISA that it warrants reversal.

CONCLUSION

Petitioners pray that the petition for writ of certiorari be granted.

Respectfully submitted,

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APPENDIX

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 97-1912

DOLORES FRAHM, *et al.*,

Plaintiffs-Appellants,

v.

THE EQUITABLE LIFE ASSURANCE SOCIETY
OF THE UNITED STATES,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 93 C 81—**David H. Coar**, *Judge*.

ARGUED NOVEMBER 3, 1997—DECIDED FEBRUARY 27, 1998

Before CUDAHY, EASTERBROOK, and EVANS, *Circuit Judges*.

EASTERBROOK, *Circuit Judge*. Insurance agents affiliated with the Equitable Life Assurance Society receive medical benefits, as do retired agents. In 1988 the Equitable instituted a copayment program for all active and some retired agents; its right to do this was secure under both the medical care plan and the summary plan descriptions, which reserved the right to change the plan's terms (or end the plan altogether) at any time. See *Murphy v. Keystone Steel & Wire Co.*, 61 F.3d 560, 565 (7th Cir. 1995); *Senn v. United Dominion Industries, Inc.*, 951 F.2d 806, 814-16 (7th Cir. 1992). In 1991 the Equitable made additional changes for active agents, giving them a choice of plans but also

(the district judge found) establishing "significantly higher payment obligations on its participants and beneficiaries with respect to premiums, deductibles, co-payments, and maximum out-of-pocket limitations. It also imposed certain cost-sharing obligations, even on those who had been exempted from earlier cost-sharing measures." In 1993 the Equitable extended the active agents' medical benefits program to all retired agents under the age of 65. Six affected retirees filed this suit under ERISA. The district judge conducted a bench trial and entered judgment for the Equitable after concluding that none of plaintiffs' theories justified stripping the employer of its reserved power to change the health plan at any time—a power it was free to use without having to show that the changes were beneficial to the active or retired agents. See *Lockheed Corp. v. Spink*, 116 S. Ct. 1783 (1996); *Johnson v. Georgia-Pacific Corp.*, 19 F.3d 1184 (7th Cir. 1994).

Plaintiffs sought to represent a class of all retired agents who preferred the old plan to the new. The district court certified the case as a class action to the extent it presents the question whether retirement causes health benefits to vest at whatever level was in place on each agent's retirement date and granted summary judgment for the Equitable, finding the reservation-of-rights clauses in the plan (and summary plan descriptions) too clear to admit of argument. Plaintiffs have not appealed from this aspect of the judgment. What led to the trial was not ambiguity in the plan or associated documents, as in *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603 (7th Cir. 1993) (en banc), but conflicting evidence about representations made to the plaintiffs personally. They contended that the Equitable had made individual contracts with them establishing rights on top of those created by the health benefits plan; they also argued that oral statements and letters during discussions about their retirements violated the employer's fiduciary duty under ERISA or estopped it to enforce the plan according to its terms. On these issues the district court declined to certify a class—and sensibly so. Plaintiffs relied on Fed. R. Civ. P.

23(b)(3), and a judge may certify a class under that subdivision only if "the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and . . . a class action is superior to other available methods for the fair and efficient adjudication of the controversy." Common questions predominated with respect to the vested-benefits claim; for all other claims everything depends on what was said or sent to each agent personally, and different benefits advisers said or wrote different things to different agents. Individual rather than class litigation is the best way to resolve person-specific contentions when the stakes are large enough to justify individual suits. *Sprague v. General Motors Corp.*, 133 F.3d 388, 397-99 (6th Cir. 1998) (en banc); *In re Rhone-Poulenc Rorer Inc.*, 51 F.3d 1293 (7th Cir. 1995). What is more, plaintiffs' request that we direct the district judge to certify the case as a class action across the board calls into question their adequacy as class representatives. See Fed. R. Civ. P. 23(a)(4). They litigated and lost; do they want to take all other retirees down in flames with them? "[A] class representative who has lost on the merits may have a duty to the class to *oppose* class certification, to avoid the preclusive effect of the judgment". *Bieneman v. Chicago*, 838 F.2d 962, 964 (7th Cir. 1988) (emphasis added). Plaintiffs' request to extend the class certification is not contingent on prevailing on the merits, and anyway Rule 23's criteria do not depend on who wins in the end. *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 176-78 (1974). But because the district judge did not abuse his discretion in concluding that the case fails to satisfy Rule 23(b)(3), we need not decide whether plaintiffs also fall short as representatives of other retirees' interests.

Let us begin with the plaintiffs' argument that the Equitable made with each of them a bilateral contract whose terms differ from those of the firm-wide health care plan. Each plaintiff claims a right, for life, to the health care benefits in force on his or her date of retirement. The Equitable denies that a personal agreement is possible, but we

see no reason in principle why not. A pension plan must be established as a trust, and for that reason it is hard to create single-employee pension contracts—although employers can make promises that work very much *like* pensions, provided they fall outside of ERISA. Compare *Nagy v. Riblet Products Corp.*, 79 F.3d 572 (7th Cir. 1996), with *Bartholet v. Reishauer A.G. (Zürich)*, 953 F.2d 1073 (7th Cir. 1992). Welfare benefit plans, a category that includes medical plans, 29 U.S.C. §1002(1)(A), may be set up informally and funded by an employer's general revenues. Almost any fringe benefit other than a pension is a "welfare plan" under the catchall clause in §1002(1)(B)—including vacation pay, holiday bonuses, severance payments, and other elements of compensation that are not directly reflected in the hourly wage. (All of these examples are listed in 29 U.S.C. §186(c), to which §1002(1)(B) refers. See also *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987).) Bilateral agreements on the length of vacation and amount of severance pay are common, and if these are proper then bilateral agreements about health care also must be proper. A firm could award severance pay equal to the expected difference between the firm's medical plan and full coverage, leaving the employee to buy a policy covering the gap. If this is proper, what's wrong with a promise to provide medical care in kind? The sixth circuit's en banc decision in *Sprague* observes that plans must be in writing, which sets limits on the scope of bilateral agreements, but the court did not deny that such agreements are possible if required forms are observed.

A conclusion that bilateral contracts about welfare benefits are *possible* gets plaintiffs nowhere, however, unless they also established that they formed such contracts. The district court held that they had not done so, principally because their early retirements did not give the Equitable any consideration for a promise of lifetime benefits. Plaintiffs not only did not give the Equitable a benefit but also, the district court remarked, did not incur any detriment: they remain eligible to sell the Equitable's policies on the

same terms as active agents, and all six have taken advantage of this opportunity. Even if some consideration can be located in the record (the retired agents say that the Equitable stopped matching their FICA taxes), plaintiffs face a greater hurdle, the district court found: "None of the plaintiffs here entered into any special written agreement with Equitable in which the cost of their health insurance was 'locked in'". This finding, which is not clearly erroneous, makes it impossible for plaintiffs to prevail on a contract theory. For one basic element of a long-term contract is a writing signed by the party to be bound. ERISA provides that pension plans must be established in writing, see 29 U.S.C. §1102(a)(1), which is a long way toward a statute of frauds—as is the Supreme Court's observation that under ERISA "every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995). Although §1102(a)(1) does not cover all possible ground—it leaves open, for example, the possibility that a written plan may be combined with an oral promise, such as an undertaking to give a worker twice the benefits so established—the utility of reducing retirement promises to writing and avoiding arguments about who said what to whom are so fundamental to both ERISA and contract law that an extension of the writing requirement to all long-term commitments is an inescapable ingredient of the federal common law slowly accumulating in ERISA's shadow. *Sprague* made this extension, and sensibly so. Cf. *Mohr v. Metro East Mfg. Co.*, 711 F.2d 69 (7th Cir. 1983) (departure from terms of a collective bargaining agreement permissible only if in writing). All ten judges who sat in *Bidlack* relied on writings; none suggested that a wholly oral promise could require the employer to provide lifetime benefits. The district court wrapped up: "Because the evidence does not support a finding that plaintiffs entered into separate bilateral contracts with Equitable at the time of retirement, Equitable cannot be found liable under a breach of bilateral contract theory." No more need be said about the contract theory.

Next comes the argument that statements made to the retirees violated the Equitable's duty as a fiduciary under the plan (that is, as the plan's administrator). ERISA requires a trustee or other fiduciary to administer a plan "solely in the interest of the participants and beneficiaries" of the plan. 29 U.S.C. §1104(a)(1). This statute was the basis of *Varity Corp. v. Howe*, 516 U.S. 498 (1996), which held that an employer may not bilk employees into surrendering their pensions. (The strategy in *Varity* was to form a new corporation, bamboozle the employees into transferring their pension claims from a solvent firm to the new and thinly capitalized one, and then pull the plug on the new corporation, leaving the employees in the lurch and freeing the investors from the pension obligations.) And *Varity* is the basis of the retired agents' claim that they, too, are entitled to redress for a breach of fiduciary duty. They contend that §1104(a)(1) is a guarantor of accurate information at all times. Any error in communicating a plan's terms, according to plaintiffs, violates the statutory duty and entitles the recipients of the information to the benefits promised orally, rather than to those in the plan documents. Arguments of this kind are becoming common in *Varity*'s wake, see *Librizzi v. Children's Memorial Medical Center*, No. 97-1934 (7th Cir. Jan. 26, 1998); *Sprague*, 133 F.3d at 404-06.

The claims made in *Varity* fell comfortably within the statute. The firm devised a scheme that transferred the corpus of the pension trust from the plan participants to the investors, a step that it was forbidden to take directly. Unlike Varity, the Equitable did not undertake a campaign of disinformation that led employees to surrender their benefits. The district court found (and again the finding is not clearly erroneous) that the Equitable trained its benefits staff to give correct advice. There has been no raid on plan assets (it has none; the Equitable's plan is a pay-as-you-go enterprise). Even when a plan is unfunded, §1104(a)(1)(A) has bite in a sense familiar to corporate law: it imposes on the plan administrator and other fiduciaries a

duty of loyalty, an obligation to act in the participants' interest. Deliberately favoring the corporate treasury when administering (as opposed to framing the terms of) a plan is inconsistent with the statute. See Daniel R. Fischel & John H. Langbein, ERISA*'s Fundamental Contradiction: The Exclusive Benefit Rule*, 55 U. Chi. L. Rev. 1105 (1988). A duty of *loyalty* must be distinguished, however, from a duty of *care*. A corporate manager is the investors' fiduciary and must act loyally in their interests. But slipups in managing any complex enterprise are inevitable, and negligence—a violation of the duty of care—is not actionable. Quite the contrary, in corporate law managers rarely face liability even for gross negligence; if knowing how best to run a firm is a hard task for full-time managers, it is an impossible task for judges, who lack both the expertise and the incentives of managers.

Running a benefits plan is just one aspect of running a corporation, and the managers (and other employees) of a firm are no less apt to err in one endeavor than in another. Efforts to administer any complex plan fall short of the ideal. Some employees of a large firm will receive bad or misleading advice. Many ideas are hard to convey or grasp. Plans are complex, and the possibility of change in the plans makes exposition and decision difficult. How best should a benefits department express the idea that although it is the employer's current *policy* to freeze the benefits of retirees, this is not its legal *obligation*? Many persons, including some in the benefits department, won't grasp the difference when the policy has been unchanged for decades. Consider the letter on which the plaintiffs place their greatest reliance, a letter from the head of the benefits department to an agency manager, who then gave advice to three of the plaintiffs:

> Historically it has been the Equitable's position to consider people retiring on the effective date of a change to be considered "inactive" on that date and not affected by the changes. Although this "rule" is not cast in stone, nor required legally, it nonetheless remains our position.

> Consequently, Equitable employees, managers and agents returning on or before January 1, 1991 will continue to be covered under the Pre-1991 health plan with contributions, deductibles, stop loss and all other provisions of that plan applying.

When that letter was sent (August 1990) it was an accurate statement not only of the Equitable's practice but also of its intentions with respect to the amendments of 1991. Agents who retired in 1990 retained the benefits of the old plan, while those who remained received lower benefits. But in 1992 the Equitable changed its mind, as the letter had intimated that it could, and applied the new plan to retirees in 1993. The letter was technically accurate yet potentially misleading to someone who had a decision to make; it did not (and could not) provide complete information about what would happen to benefits some years hence. Plaintiffs testified to additional advice, much of it oral, that stressed the availability of "lifetime" benefits and omitted the qualifier that "this 'rule' is not cast in stone, nor required legally". Some benefits counselors may have had trouble distinguishing statements of the Equitable's current intention from statements about the contents of the plan. Some readers must have mentally added the word "unreduced" after a word such as "lifetime." Yet unless §1104(a)(1) is a guarantor of accurate information at all times and for the indefinite future—unless it creates not only a duty of care, but also a duty of prevision—then claims that one or another bit of advice was misleading do not violate this statute.

Section 1104(a)(1)(A) creates a duty of loyalty. Section 1104(a)(1)(B) creates a duty of care by requiring each plan's administrator to use "the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims". This duty addresses overall management of the plan, particularly of its assets, rather than the quality of oral advice to beneficiaries. We need not

decide whether (and, if so, how) §1104(a)(1)(B) bears on oral advice, because, whatever this section does, it does not create a standard of absolute liability. A duty of care is not a duty of prevision. A plan administrator satisfies §1104(a)(1)(B) by taking appropriate precautions—such as training the benefits staff and providing accurate written explanations—even if the precautions sometimes prove to be insufficient.

Treating §1104(a) as establishing a duty to give plan participants whatever benefits someone on the staff led them to believe were available would undermine an essential principle established by ERISA: there are no oral variances from written plans. E.g., *Central States Pension Fund v. Gerber Truck Service, Inc.*, 870 F.2d 1148 (7th Cir. 1989) (en banc); *Central States Pension Fund v. Joe McClelland, Inc.*, 23 F.3d 1256, 1257-58 (7th Cir. 1994). Many cases in this line reject claims for medical benefits by plan participants who say that someone told them that one or another procedure was covered and incurred expenses in reliance on the assurance. E.g., *Plumb v. Fluid Pump Service, Inc.*, 124 F.3d 849, 856 (7th Cir. 1997); *Schoonmaker v. Employee Savings Plan of Amoco Corp.*, 987 F.2d 410 (7th Cir. 1993); *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992); *Vershaw v. Northwestern National Life Insurance Co.*, 979 F.2d 557 (7th Cir. 1992). ERISA requires firms to establish their plans in writing, to provide participants with written summary plan descriptions, and to furnish the full text of the plans on request. All of these provisions suppose that the written terms are the effective terms. Havoc would ensue if plans meant different things for different participants, depending on what someone said to them years earlier. Memory is weak compared to the written word, and there is a substantial risk that participants will not correctly recall what was said, will exaggerate (in their favor) what they heard, or will simply prevaricate in order to improve their position. Employers could do little to protect themselves against such claims—which is why ERISA calls for writings, and why we concluded above

that a rule akin to the statute of frauds applies to all claims based on bilateral contracts. If it is hard now to administer plans that apply to all participants, it is impossible to see how any employer could administer a plan that meant something different for each participant, where the difference was not committed to writing. What is more (and per-haps worse), binding the plan's sponsor to the oral advice of its benefits staff might lead the employer to discontinue giving advice, telling participants to read the documents and draw their own conclusions. That step would protect employers, but it very likely would increase the level of misunderstanding among participants. We do not think that §1104(a)(1)(B) takes back with the left hand the primacy of the written word that ERISA establishes with the right hand. *Sprague* said much the same thing, in a passage apropos here too:

> GM's failure, if it may properly be called such, amounted to this: the company did not tell the early retirees at every possible opportunity that which it had told them many times before—namely, that the terms of the plan were subject to change. There is, in our view, a world of difference between the employer's deliberate misleading of employees in *Varity Corp.* and GM's failure to begin every communication to plan participants with a caveat.

133 F.3d at 405. The district court's finding that the Equitable did not set out to deceive or disadvantage plan participants therefore forecloses plaintiffs' claim under §1104(a)(1).

Plaintiffs repackage their fiduciary-duty argument as a contention that the Equitable is "estopped" to change the medical plan, but the semantic change actually weakens the point. It does not avoid the need for writings, which is why we held in *Russo v. Teamsters Pension Fund*, 984 F.2d 762 (7th Cir. 1992), that principles of estoppel are inapplicable to oral assertions in ERISA matters. Because some of the statements are contained in letters sent to the retirees, we press on. Federal practice (this variation of plaintiffs'

claim depends on federal common law under ERISA) limits estoppel to cases in which one party has made an incorrect representation of fact, on which another reasonably relied to his detriment. *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51, 59-61 (1984). See also *Restatement (2d) of Torts* §894 (1979); *Sprague*, 133 F.3d at 403-04. Statements of the kind to which the plaintiffs point—that retirees should expect to receive the health benefits in force at the date of their retirement, and that the Equitable did not plan to change this feature of its plans—were, when made, not false statements of fact. They were not false, because they accurately informed the agents about the operation of the plans the Equitable then had in force; and to the extent they were forward-looking, it was not clearly erroneous for the district court to conclude that they were statements not of "fact" but of present intention. That's a vital distinction in the law of estoppel (and its cousin, the law of fraud). See *Vaughn v. General Food Corp.*, 797 F.2d 1403 (7th Cir. 1986). Representations about plans and intentions could be false if, at the time the statements were made, the speaker actually had a different intention (*Ballone v. Eastman Kodak Co.*, 109 F.3d 117 (2d Cir. 1997), appears to have concerned such a situation), but the district court found that plaintiffs had not proved lies of this kind. Instead the evidence showed that the statements were honest (if at times incautious) projections of present plans into the future. As it happened, higher management of the Equitable changed course in 1992, but this did not make the earlier statements false.

Reliance is a second hurdle for the plaintiffs. In federal law, a person cannot rely on an oral statement, when he has in hand written materials disclosing the truth. See *Teamsters Local 282 Pension Trust Fund v. Angelos*, 762 F.2d 522, 530 (7th Cir. 1985). We have applied this principle repeatedly, in a variety of situations. *Minasian v. Standard Chartered Bank, PLC*, 109 F.3d 1212, 1215 (7th Cir. 1997) (an oral statement contradicted by written documents cannot be fraud in contract law); *Carr v. CIGNA*

Securities, Inc., 95 F.3d 544 (7th Cir. 1996) (same principle in securities law). Our most recent application of this principle is to a mixed fiduciary-duty and estoppel claim under ERISA. *Schmidt v. Sheet Metal Workers' Pension Fund*, 128 F.3d 541, 546 (7th Cir. 1997), rejects a claim that bad advice delivered verbally entitles plan participants to whatever the oral statement promised, when written documents provide accurate information. Both the plan and the summary plan descriptions accurately told the plaintiffs that the Equitable had retained the right to change or even discontinue the medical-care plan. See also *Gable v. Sweetheart Cup Co.*, 35 F.3d 851 (4th Cir. 1994).

Then there is the requirement of detrimental reliance. The district judge found that, although plaintiffs may have relied on the advice they received, they did not do so to their detriment. Retired agents' benefits are not inferior to those active agents enjoy. Had plaintiffs remained in active employment, their medical benefits would have diminished in January 1991. By retiring before then, they retained the benefits of the old plan for another two years. So *none* of the elements of an estoppel has been established: no false statements of fact, no reliance, and no detriment.

The retired agents are worse off than they would be if the Equitable had left its old plan in force, but that has nothing to do with "estoppel." It stems from the fact that the employer used its power to change the plan. Plaintiffs' arguments really are efforts to avoid, through the back door, the holdings of *Bidlack*, *Murphy*, and *Senn* that a power expressly reserved may be used—and used, as *Lockheed* and *Georgia Pacific* hold, without any need to consider the best interests of employees. See also *Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810 (7th Cir. 1997). When setting and changing the terms of a plan, the employer may act to promote its own interests, just as it may do when setting wages. In the short run use of this power may injure retirees; but in the longer run, knowledge that plans may be changed encourages employers to make better offers to their labor force. If employers knew that they were

locked in, they would be more conservative in making promises, to the potential detriment of the workers. See *Heath v. Varity Corp.*, 71 F.3d 256, 258 (7th Cir. 1995); *Georgia-Pacific*, 19 F.3d at 1189-90. What protects retirees is not a legal rule of fiduciary duty or estoppel, but the employer's desire to maintain a reputation for honest dealing with its workers; otherwise it will have difficulty attracting and retaining a skilled work force. The Equitable did not cut off its retirees; it treats retirees the same as active workers, which provides a form of vicarious protection for their interests. ERISA permits other firms to compete by offering vested benefits. But plaintiffs chose to work for a firm that had announced that it was reserving the right to reduce or eliminate health benefits, and they have no legal right to prevent the firm from exercising the option it retained.

AFFIRMED

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

Not Reported in F.Supp.
(Cite as: 1997 WL 159352 (N.D.Ill.))

Delores FRAHM, Royce Terry, Gerald Colson, Laurence Wilneff, Claire Goldberg, and Deborah Cooper, on behalf of themselves and on behalf of a class of persons similarly situated, Plaintiffs,

v.

The EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES, Defendant.

No. 93 C 0081.

United States District Court,
N.D. Illinois,
Eastern Division.

March 25, 1997.

MEMORANDUM OPINION AND ORDER

COAR, District Judge.

This matter is before the court for a decision on the merits following a bench trial. The following Findings of Fact and Conclusions of Law are entered pursuant to Federal Rule of Civil Procedure 52(a), after having examined the entire record and after having determined the credibility of the witnesses.

Findings of Fact[1]

A. Jurisdiction and Parties

1. This court has jurisdiction over this matter under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq.

2. Venue is proper in this district.

3. Defendant The Equitable Life Assurance Society ("Equitable") is an insurance company engaging in insurance business throughout the United States and in the Northern District of Illinois.

4. Plaintiffs Delores Frahm, Royce Terry, Gerald Colson, Laurence Wilneff, Claire Goldberg, and Deborah Cooper are all retired insurance agents who were associated with Equitable.

5. Although all of the plaintiffs technically are considered "retired" agents, each plaintiff has the right to sell Equitable's products and receive commission income under a retired agent's contract, and all of them have done so.

6. All of the plaintiffs took early retirement prior to February 1, 1991.

7. Three of the plaintiffs, Colson, Goldberg, and Wilneff, retired effective January 1, 1991.

8. Of the remaining plaintiffs, Terry retired effective June 1, 1988, Frahm retired effective December 1, 1988, and Cooper retired effective December 1, 1989.

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[1] The following findings of fact have been compiled by the court, consistent with its own findings, from the parties' proposed findings of fact and from other evidence before the court.

9. All of the plaintiffs were under age 65 at the time of retirement.

B. Equitable Health Plan

10. All of the plaintiffs were eligible for and received health care benefits from Equitable that continued after their retirement.

11. Prior to their retirement and continuing to the present, plaintiffs have received medical coverage under Equitable's United States Employees, Managers and Agents Health Care Plan ("Equitable Health Plan" or "Plan").

12. The version of the Equitable Health Plan effective since January 1, 1985 has provided for continuation of health care coverage if employees retired directly from service before age 65.

13. The Equitable Health Plan was summarized for participants in a series of benefits books entitled "Agents Benefits," which were the Summary Plan Descriptions ("SPDs") that ERISA requires employers to distribute to all plan participants.

14. All of the Equitable Health Plan documents governing the health care benefits provided to active and retired employees, agents, and managers have specifically reserved Equitable's right to make changes or terminate the health care benefits.

15. The benefits book entitled "Your Agent Benefits Program," effective January 1, 1976, contained the following language:

> The Equitable expects to continue the plans or program indefinitely. However, it reserves the right to

> change or terminate a particular plan or the program at any time.

16. The benefits booklet entitled "Your Benefits Book (For Employees)" effective November 1, 1977, contained the following language:

> The Equitable or a participating subsidiary reserves the right to change or terminate its particular plan or program at any time.

17. The benefits booklet entitled "About Your Health Benefits (Retirees)" effective through December 31, 1981, contained the following language:

> The Equitable or a participating subsidiary reserves the right to change or terminate the group benefit program at any time.

18. The benefits booklet entitled "About Your Benefits (For Agents)" effective August 1, 1982, contained the following language:

> The Equitable or a participating subsidiary reserves the right to change or terminate the group benefit program or a particular plan at any time.

19. The particular benefits booklet upon which plaintiffs rely for their claim to fixed lifetime benefits, entitled "Agents Benefits" and effective January 1, 1985, contains the following language:

> The Equitable or a participating subsidiary reserves the right to change or terminate the group benefit program or a particular plan at any time.

20. The Equitable Health Plan document itself contained language expressly reserving Equitable's right to amend or terminate the Plan at any time. Specifically, it stated:

> The Equitable shall have the right at any time by instrument in writing, duly executed and acknowledged and delivered to the Trustee, to modify, alter or amend the Plan in whole or in part, provided, however, that no such amendment shall diminish or eliminate any claim for any benefit to which a Member of Dependent shall have become entitled to prior to such amendment.

21. Acting pursuant to its reserved right to change health benefits, Equitable made changes to the Equitable Health Plan affecting benefits coverage and charges over the years before plaintiffs retired.

22. For instance, in 1988 the Plan was amended to add a new cost-sharing provision for future retirees, in which the retirees would pay a portion of the total cost based on their particular length of service with Equitable.

23. Plaintiffs Goldberg and Cooper became subject to this cost-sharing provision.

24. Equitable made other changes to benefits provided to participants, including introduction of medical case management and coordination of benefits requirements.

C. Implementation of the CHOICE Program

25. On October 15, 1990, Equitable announced that it was amending its health care plan to offer benefits under a program called CHOICE, which would take effect for active employees, agents, and managers as of January 1, 1991.

26. CHOICE offered a range of health care options, including indemnity coverage substantially similar to that previously provided under the Equitable Health Plan.

27. CHOICE also offered Equitable employees for the first time a managed care option resulting in substantially reduced medical expenses for employees.

28. However, CHOICE imposed significantly higher payment obligations on its participants and beneficiaries with respect to premiums, deductibles, co-payments, and maximum out-of-pocket limitations. It also imposed certain cost-sharing obligations, even on those who had been exempted from earlier cost-sharing measures.

29. CHOICE also differed in coverage from the Equitable Health Plan in areas such as mental health benefits and prescription drug reimbursement.

30. At the same time CHOICE was adopted for active employees and agents, CHOICE coverage was also provided to Equitable employees, agents, and managers who would retire on or after February 1, 1991.

31. Equitable employees, agents, and managers under age 65 who retired before February 1, 1991, however, continued to receive health care benefits under the previous Indemnity program.

32. Approximately two years after CHOICE was initially adopted, Equitable announced on October 15, 1992 that it intended to provide CHOICE coverage to all retirees under age 65 effective January 1, 1993.

33. The Equitable's decision to cover eligible retirees under age 65 under the CHOICE provisions was an effort to manage escalating medical costs and reduce Equitable's total operating expenses.

34. In 1991, Equitable experienced a significant net after-tax operating loss.

35. The application of CHOICE to all retirees under age 65 was deemed a necessary cost-reduction measure as part of an effort to restore the company's financial health.

36. Additionally, the Financial Accounting Standards Board ("FASB") had recently imposed financial reporting requirements mandating that employers set forth their projected overall retiree medical costs as a liability on their financial statements.

37. These reporting requirements provided further incentive for Equitable to institute cost-reduction measures to minimize the financial-statement effect of retirees' benefits costs.

38. Equitable amended the Equitable Health Plan to extend the CHOICE Program to all retirees by adding the following provision:

> Article XII. Retiree Coverage
>
> 12.1 Benefits. The level of health benefits available to Retirees is as follows:
>
> (a) Retirees who are under age 65 in the year prior to the current Plan Year: Regardless of their retirement date, such Retirees are eligible for benefits under this Plan pursuant to the provisions of the CHOICE program. . . .

39. As indicated by this provision and the minutes of the Officer's Committee on Benefit Plans, Equitable expanded the CHOICE program from active employees to retirees as a change in the health plan benefits provided for retirees under the Equitable Health Plan, not a replacement of one plan with another or a transfer of retirees to a different plan.

40. At the time CHOICE was extended to the retirees, each affected retiree received a brochure describing CHOICE and setting forth enrollment information.

41. Like all plan documents before it, the CHOICE brochure contained language expressly reserving Equitable's right to change or discontinue health care benefits.

42. The brochure notified retirees that to continue receiving health care coverage in 1993 they had to elect coverage under CHOICE by November 13, 1992.

D. Representations Made to Individual Retirees/Plaintiffs

43. On October 31, 1990, Laurence Wilneff, in a letter to Equitable, announced his decision to elect early retirement effective January 1, 1991.

44. On December 12, 1990, Wilneff received a letter from Equitable saying he would be receiving an explanation of his benefits as soon as possible.

45. The December 12, 1990 letter Wilneff received did not give him any information as to what his benefits would be upon retirement.

46. Wilneff testified that his agency manager, Jim Schlesinger, had told him that "my health insurance benefits and premiums would be frozen at the level they were at that particular time" if he retired. Schlesinger denied telling Wilneff that or even knowing what Wilneff's benefits would be.

47. After Wilneff retired, on January 22, 1991, he received a letter from Equitable laying out the various benefits he would receive.

48. The letter provides that "you will continue to be insured under the current Health Insurance Plan for the remainder of your lifetime." The letter does not say that benefits or charges would be "frozen." The letter instructs

Wilneff to review his Benefits Book for additional information.

49. Since being placed on CHOICE, Wilneff has incurred approximately $3000 in costs over those that he would have paid under the terms of the previous Equitable Health Plan.

50. Gerald Colson retired effective January 1, 1991.

51. On October 28, 1990, Colson sent a letter advising Equitable that he was considering retirement and was in need of information regarding his benefits.

52. Colson sent a duplicate of the same letter again on December 6, 1990, stating that he had not received a response.

53. However, in Colson's December 6 letter, he crossed out the language from the October 28 letter that stated "I am contemplating taking retirement" and instead wrote "I wish to take retirement, as of December 31, 1990."

54. That December 6 letter affirmatively expressing Colson's intent to retire was dated before his December 7 telephone call with an Equitable benefits advisor in which Colson claimed that he received oral commitments to "freeze" his benefits under the Equitable Health Plan.

55. In a third letter dated December 10, 1990, Colson complained that the letters he received from Equitable did not provide the requested information regarding his benefits.

56. Despite not having received written information from Equitable, Colson made his decision to retire effective December 31, 1990, as indicated by his December 6, 1990 letter and his December 10 letter, because he "received this information over the phone verbally from

Laurie Agin as to what [his] benefits would be." Colson testified that he therefore retired with the goal of retaining coverage under the Equitable Health Plan.

57. Equitable subsequently sent Colson a letter from Laurie Agin dated December 26, 1990, which explained Colson's various benefits as of the retirement date of January 1, 1991.

58. There are no representations in the letter about the cost of health benefits after retirement.

59. The letter says that "you will continue to be insured under the current Health Insurance Plan for the remainder of your lifetime."

60. The letter does not provide that benefits would be "frozen" or make any similar commitment or specify any particular benefits or charges for health benefits.

61. The letter instructs Colson to review his Benefits Book for additional information.

62. Colson received no other letters about his retiree benefits until March 27, 1991, three months after he retired.

63. Colson worked at the Kanter Agency. His agency manager, Cal Kanter, provided Colson with a copy of an August 24, 1990 letter to Kanter from a senior Equitable officer, Robert Keane, in which Keane said that "it has been The Equitable's position to consider people retiring on the effective date of a change to be considered 'inactive' on that date and not affected by the changes." However, the letter further explained that "although this rule is not cast in stone, nor required legally, it nonetheless remains our position."

64. Kanter used this letter to warn Colson and other agents at his agency that their health benefits as retirees were "not cast in stone" and could be changed.

65. Colson received benefits books (SPDs) while he was an active agent and was familiar with the provision reserving Equitable's right to amend or terminate plans.

66. Colson knew of benefit plan changes introduced by Equitable while he was an active agent that were adverse to active or retired agents, specifically medical case management, coordination of benefits, and cost sharing for new retirees.

67. After implementation of the CHOICE program for pre-65 retirees, Colson has had to pay higher premiums, deductibles, and other costs. Those increased charges total at least $6100.

68. Claire Goldberg retired on January 1, 1991.

69. Goldberg sent Equitable a letter on October 19, 1990 notifying Equitable of her preliminary decision to retire.

70. On November 30, 1990, benefits consultant Laurie Agin wrote to Goldberg in response to her request for retirement information. The letter says that "you will continue to be insured under the current Health Insurance Plan for the remainder of your lifetime." The letter does not provide that her benefits or costs would be frozen.

71. The letter instructed her to review her benefits book for additional information and advised her that she would be subject to the cost-sharing changes Equitable was implementing.

72. Goldberg's testimony about claimed telephone conversations was to the effect that she was told she could retire and stay under the Equitable Health Plan instead of CHOICE, not that she was promised fixed or frozen benefits.

73. Goldberg worked at the Kanter Agency. Her agency manager, Cal Kanter, provided Goldberg with a copy of the August 24, 1990 letter from Robert Keane. Kanter used this letter to warn Goldberg that her benefits could change in retirement.

74. Goldberg received benefits booklets while an active agent, and she testified that she was familiar with the reservation of rights provision of the 1985 booklet when she was considering retirement.

75. Goldberg was aware before she retired that Equitable had changed the health program to include medical case management and cost sharing for retirees.

76. Since being placed on CHOICE, Goldberg has incurred costs and charges in excess of what she had been required to pay under the previous terms of the Equitable Health Plan. Those costs total between $10,000 and $12,000.

77. Deborah Cooper retired on December 1, 1989.

78. Cooper's claims are based solely on correspondence exchanged with Equitable, not on conversations.

79. On July 26, 1989, Cooper sent a letter to the Benefits Department at Equitable regarding the possibility of retiring, and inquiring as to how her retirement would affect cost sharing on benefits.

80. Equitable sent a letter in response to Cooper's inquiries on July 28, 1989. The letter states that if Cooper

retired while paying full health insurance premiums, she would continue to pay them for her lifetime, and described lower rates for more productive agents.

81. On October 17, 1989, Cooper wrote to Equitable indicating that she intended to take early retirement on December 1, 1989.

82. These letters were the complete exchange of correspondence between Cooper and Equitable concerning early retirement.

83. On February 20, 1990, after Cooper retired, she received a letter outlining her benefits. The letters says that she would continue to be insured under the Health Insurance Plan for 24 years and 10 months. The letter also states that as of January 1, 1990, her health insurance deductible would be frozen.

84. The letter instructs Cooper to review her Benefits Book for additional information.

85. Cooper was aware at all times of the reservation of rights language in the SPDs.

86. At trial, Cooper testified on cross-examination that Equitable could change her coverage and that which was charged for the coverage, but could not eliminate her lifetime coverage.

87. In a portion of Cooper's deposition testimony read into evidence, Cooper admitted that Equitable had reserved the right to change her terms of coverage.

88. Cooper estimates that she has incurred excess health insurance costs since her enrollment in CHOICE in the amount of $4000 to $5000.

89. Delores Frahm retired on December 1, 1988.

90. On April 11, 1988, Frahm sent a letter to Equitable in which she requested a letter on available retirement benefits at age 62 and 65.

91. On May 26, 1988, Frahm received a letter from Grace Duenna, benefits consultant for Equitable, in response to her April 11 letter.

92. In this letter, there was no information about future health benefits, only an estimate of life insurance benefits.

93. Frahm did not receive any other letter from Equitable outlining her benefits before her December 1, 1988 retirement date.

94. On January 11, 1989, after she retired, Frahm received a letter that outlined her agent retirement benefits. This letter stated that she would continue to be insured under the Equitable Health Plan for the remainder of her lifetime. The letter also stated that her deductible would be frozen at $100 for self-coverage. Finally, the letter instructed Frahm to review her benefits book for additional information.

95. Frahm received benefits booklets with reservations of rights provision while an active agent and was aware of mandatory cost-containment procedures, medical case management, coordination of benefits, an increased deductible and retiree cost sharing, all introduced while she was an active agent.

96. The increase in deductible and premium costs since Frahm was placed in CHOICE has cost her between $2000 and $3000 in excess of what she would have paid under the previous terms of the Equitable Health Plan.

97. Royce Terry retired on June 1, 1988.

98. Terry claimed at trial that numerous agency managers, Equitable benefits personnel, and Equitable's president had told him that he could "lock up" health benefits by working to age 55.

99. On January 8, 1988, Terry sent a letter to Equitable's manager of retiree benefits, saying that he planned to start his retirement pension at age 55. The letter requested information regarding Terry's pension benefits; there was nothing in the letter asking for information about health benefits.

100. Terry received a response dated March 2, 1988, which provided Terry with pension figures based on actual information but did not address health benefits.

101. In response to the March 2, 1988 letter, Terry sent back paperwork to initiate his retirement.

102. Terry received a June 17, 1988 letter explaining his retirement benefits after he retired.

103. The letter stated that Terry will continue to be insured under the Plan for his lifetime, stated that he "will continue to pay for the benefit" to age 65, and specifies the "present" deductible amount.

104. The letter did not state how much Terry will pay or whether the amount would change from year to year, and did not state that his deductible was locked in, or that his coverage was locked in.

105. While Terry testified on direct examination that he retired in order to "lock up" health benefit coverage, on cross-examination he admitted writing a commission appeal letter in 1992 stating that he had retired at age 55 "due to the Equitable's ever increasing requirements for life volume."

106. Terry received benefits booklets while an active agent, knew about the reservation of rights provisions, and knew that Equitable had from time to time made changes in health benefits adverse to plan participants.

Conclusions of Law

Plaintiffs tried their case under three legal theories: (1) breach of a bilateral contract between the parties; (2) estoppel; and (3) breach of a fiduciary duty not to mislead or misinform plan participants regarding their benefits. The court will consider each of these theories in turn.

A. Breach of Bilateral Contract

Seventh Circuit law is clear that where a contract provides that benefits may be amended or terminated, those benefits do not vest and are not fixed or frozen. See *Murphy v. Keystone Steel & Wire Co.*, 61 F.3d 560, 565 (7th Cir.1995); *Senn v. United Dominion Indus. Inc.*, 951 F.2d 806, 816 (7th Cir.1992), *cert. denied*, 509 U.S. 903, 113 S.Ct. 2992, 125 L.Ed.2d 687 (1993). Thus, in its Memorandum Opinion and Order of September 29, 1995, this court ruled that any breach of contract claim in this case cannot be based on the plan documents because of the reservation of rights provisions found therein. See *Frahm v. Equitable Life Assurance Soc'y*, No. 93 C 81, 1995 WL 579282 (N.D.Ill. Sept. 29, 1995). At trial, plaintiffs therefore attempted to prove that each of them negotiated a separate bilateral contract with Equitable at the time of their retirement. These contracts allegedly provided that each of the plaintiffs' benefits plan would be "locked in" for life, and that the costs of the plan would be "frozen."

The Seventh Circuit has never recognized a bilateral contract theory in an ERISA case. Thus, plaintiffs have based their theory of recovery on the decision in *Sprague v. General Motors Corp.*, 843 F.Supp. 266 (E.D.Mich. 1994), aff'd, 92 F.3d 1425 (6th Cir.1996). In that case, General Motors offered certain employees free medical care for life as an incentive to induce them to retire early. After GM began charging increased co-payments and deductibles on those health insurance policies, the retirees sued GM for breaching its promise to provide no-cost health insurance. The court found that GM had entered into "special deals" with its early retirees that provided those retirees with vested health care benefits in exchange for defined consideration. See *id.* at 299. The court also found that those contracts were separate and apart from the company's regular health care plan. See *id.* at 299-303.

Some of the facts of the instant case are clearly similar to those found in *Sprague*—plaintiffs accepted early retirement because they assumed that they were essentially trading larger pensions and 401(k) plans for a promise of fixed-cost, lifetime health care benefits. However, these subjective beliefs are not enough to prove that plaintiffs entered into bilateral contracts with Equitable. In *Sprague*, the court found that the early retirees had entered into separate individual written contracts at the time that they retired that gave the retirees certain benefits (e.g., free lifetime health care coverage) in consideration for their right to pursue claims for age discrimination against GM. See *id.* However, in this case, there are a number of significant differences that require a result opposite from that reached by the *Sprague* court: None of the plaintiffs here entered into any special written agreement with Equitable in which the cost of their health insurance was "locked in" and in which they

gave up any legal rights as consideration. In fact, it is difficult to see what type of consideration plaintiffs did give. Plaintiffs were not required to stop working as insurance agents. Nor did they give up their right to receive commissions. Furthermore, as this court noted in its Memorandum Opinion and Order of September 29, 1995, denying similar claims for continuing health care coverage by a class of retirees,

> the alleged consideration involved here differs in a crucial respect from the consideration found sufficient in *Sprague* to support the existence of a bilateral contract. In *Sprague*, the plaintiffs executed "Statements of Acceptance" of GM's early retirement offer in which each retiree promised to release GM from liability for certain causes of action potentially connected with early retirement, including any claims for age discrimination. In this case, however, plaintiffs did not forego any of their legal rights. Instead, they claim that in exchange for an alleged promise of lifetime health coverage, they forfeited their rights to participate in Equitable's § 401(k) plan, to receive matching FICA employer contributions, to increase their life insurance benefits based upon production and to be eligible for disability insurance. Yet, as Equitable argued in its Response Memorandum to Plaintiff's Objections to the Magistrate's Report and Recommendation, every person who retires forgoes these benefits.

Frahm, 1995 WL 579282, at *8. The court finds that the "consideration" involved in this case cannot form the basis of a bilateral contract under *Sprague*. This alone is enough to bar recovery under plaintiffs' first theory. In addition, there are other facts upon which the court may rely to bar this claim. For example, the plan documents in this case, unlike those in *Sprague*, have consistently included clear reservation of rights provisions that reserve

the right to change, modify, or terminate benefits at any time. Each of the plaintiffs received the booklets that contained these provisions prior to their retirement. Under the theory of recovery recognized by the Court of Appeals in *Sprague*, these reservation of rights provisions alone would be fatal to plaintiffs' claims. As the Sixth Circuit noted, if

> a summary plan description contains both an express reservation of right provision and a promise of lifetime benefits, judgment should be granted for [defendant] . . . on the ground that the company reserved to itself the right to amend its plan at any time.

Sprague v. General Motors Corp., 92 F.3d 1425, 1438 (6th Cir.1996).

Because the evidence does not support a finding that plaintiffs entered into separate bilateral contracts with Equitable at the time of retirement, Equitable cannot be found liable under a breach of bilateral contract theory.

B. Estoppel

In order to prevail on their estoppel claims, plaintiffs must prove the following:

> (1) Equitable knowingly misrepresented or concealed a material fact;
>
> (2) plaintiffs, not knowing the truth, reasonably relied on that misrepresentation or concealment;
>
> (3) plaintiffs suffered detriment; and
>
> (4) plaintiffs had no knowledge or convenient means of ascertaining the true facts that would have prompted them to react otherwise.

Krawczyk v. Harnischfeger Corp., 41 F.3d 276, 280 (7th Cir.1994). In this case, plaintiffs have simply not met their burden of proof on all of the essential elements of their estoppel claim.

First, plaintiffs have not proven that Equitable misrepresented or concealed material facts about plan terms. The retirement letters sent to all of the plaintiffs (and the oral representations made to some of the plaintiffs) that refer to "lifetime" benefits and "frozen" costs are not sufficient to constitute misrepresentations about the plan. Kevin Clark testified that all of the letters upon which the plaintiffs rely were accurate descriptions of the health care plan as it existed at the time. However, those letters can be regarded only as statements of current plan terms and not as misrepresentations regarding the plan. Other courts have held that such statements of current intention regarding plans cannot be used to override explicit language found in plan documents. See *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 857 (4th Cir.1994), *cert. denied*, ___ U.S. ___, 115 S.Ct. 1442, 131 L.Ed.2d 321 (1995) (while references to lifetime benefits contained in non-plan documents may state company's current intentions with respect to plan, such references cannot defeat explicit reservation of right to modify contained in plan documents). Furthermore, several of the plaintiffs were notified about the letter from Robert Keane, Equitable Vice President of Executive Benefits, which stated that Equitable's position regarding the provision of health benefits to retired agents was "not cast in stone." This evidence leads to the conclusion that Equitable was careful not to suggest that its retired agents would receive permanent, fixed benefits.

Second, while it is apparent that plaintiffs may have relied to their detriment on their belief that Equitable

had promised them fixed or frozen benefits, plaintiffs have not proven that they reasonably relied on any of Equitable's representations regarding fixed or frozen costs. Plaintiffs are not unsophisticated purchasers of insurance rights, and they were in possession of plan documents that expressly disclosed Equitable's right to change their health insurance benefits. Plaintiffs also knew, or should have known, that Equitable's health insurance plan had been modified to the plan participants' detriment on a number of occasions. Thus, plaintiffs' claimed reliance on Equitable's statements in calls or letters that the cost of their benefits could never change is therefore not reasonable as a matter of law or fact. See *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 58 F.3d 896, 907 (3d Cir.1995), *cert. denied* sub nom., *Unisys Corp. v. Pickering*, ___ U.S. ___, 116 S.Ct. 1316, 134 L.Ed.2d 470 (1996) (stating that retirees' interpretation of plans as providing lifetime benefits was not reasonable as matter of law because it could not be reconciled with unqualified reservation of rights clauses in plans); *Gordon v. Barnes Pumps, Inc.*, 999 F.2d 133, 137 (6th Cir.1993) (finding no reasonable reliance where plan participants knew or should have known from express terms of plan that benefits could be altered at any time). Additionally, to the extent that some of the plaintiffs relied on telephone conversations with Equitable benefits personnel, the representations made to those plaintiffs cannot be relied upon to vary the terms of the written benefit plan. See *Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 650 (7th Cir.1993) ("[T]he [ERISA] statute does not allow oral modifications of ERISA-governed plans."); *Bartholet v. Renhaven A.G. (Zulich)*, 953 F.2d 1073, 1078 (7th Cir.1992) ("ERISA does not allow oral variances of pension plans."); accord *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 81, 822 (9th Cir.1992) ("[T]he federal common law of equitable

estoppel is not available to plaintiffs in cases involving oral amendments to or modifications of employee plans governed by ERISA because ERISA specifically addresses these issues." (citation omitted)).

Finally, plaintiffs have failed to prove that they suffered any detriment. Even though they were retired agents, plaintiffs stayed under the old health insurance plan until 1993, at which time they were moved to CHOICE. If plaintiffs had not retired and had remained active agents, they would have been moved to CHOICE two years earlier.

For the reasons set out above, the court finds that plaintiffs have not proven all of the essential elements of an ERISA estoppel claim. Therefore, their claims based on estoppel are denied.

C. Breach of Fiduciary Duty

Plaintiffs' final theory is that Equitable breached its fiduciary duties under ERISA by "affirmatively and systematically" misleading them in regard to the benefits to which they were entitled. Plaintiffs base this theory of recovery on § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). In *Varity Corp. v. Howe*, ___ U.S. ___, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996), the Supreme Court recognized such a theory of recovery, describing § 502(a)(3) as a "catchall" that provides for "appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy." *Varity*, ___ U.S. at ___, 116 S.Ct. at 1067.

In support of their breach of fiduciary duty claim, plaintiffs have relied on the decisions in *Varity* and *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 57 F.3d

1255 (3d Cir.1995), *cert. denied* sub nom., *Unisys Corp. v. Pickering*, ___ U.S. ___, 116 S.Ct. 1316, 134 L.Ed.2d 470 (1996). In *Varity*, the defendant held a meeting to persuade employees of some of its money-losing divisions to change employers and benefits plans. The defendant reassured the employees that their benefits would remain secure when they transferred to the new division. In fact, the defendant knew that the new division was insolvent from the outset, and the employees who transferred their employment and benefits to that division ultimately lost their non-pension benefits. *Varity*, ___ U.S. at ___, 116 S.Ct. at 1068-69. The Court accepted the district court's finding that Varity had engaged in "deliberate deception" in informing plan participants about their benefits. See *id.* at ___, ___ U.S. at ___, ___ - ___, 116 S.Ct. at 1069, 1071-74. The Court concluded that this amounted to a breach of the employer's fiduciary duty of honesty required by ERISA. *Id.*, at ___, ___ U.S. at ___ - ___, 116 S.Ct. at 1073-74.

In *Unisys*, retired employees sought relief under a theory of breach of fiduciary duty, based on Unisys's termination of their post-retirement medical benefit plans. The SPDs contained explicit lifetime benefits language, see *Unisys*, 57 F.3d at 1259 ("[c]overage continues for you for life"), but also contained reservation of rights clauses in other sections, see *id.* ("The Company . . . reserves the right to change or end [the plans] at any time."). In addition to these SPD provisions, the plaintiffs also received information through various informal oral and written communications that their medical benefits would be "for life." *Id.* "'The message that medical benefits would last for life was confirmed repeatedly and systematically throughout the [ ] organization, by all levels of management.'" *Id.* at 1260 (quoting district court's opinion). The Third Circuit held that the defendant

breached its fiduciary duties to early retirees when it broke its promise to provide lifetime health care to those employees, who had been induced to retire on the basis of such assurances.

The facts of the instant case do not lead to the conclusion that Equitable breached any of its fiduciary duties to the plaintiffs. The letters upon which four of the plaintiffs rely do not clearly state that their benefits would be "locked in for life." (See, e.g., Plaint. Exh. § (letter from Laurie Agin to Gerald Colson); Plaint. Exh. U (letter from Taly Herz to Laurence Wilneff); Plaint. Exh. X (letter from Laurie Agin to Claire Goldberg); Plaint. Exh. N (letter from Gary Griffin to Royce Terry)). Plaintiff Cooper received no written communication from Equitable regarding her benefits upon retirement. The letter to plaintiff Frahm is the only one that states that any benefits would be "frozen." (See Plaint. Exh. L (letter from Grace Duenna to Delores Frahm, stating that her "health Insurance deductible will be $100 for self coverage and will remain frozen at this level")). Yet, that evidence is insufficient to prove the existence of the kind of "affirmative or systematic misrepresentations" that were present in *Unisys*. Furthermore, unlike the situation in *Unisys*, the SPDs in this case do not contain any provisions that promised lifetime benefits. Thus, there was no language in the SPDs that contradicted the reservation of rights provision that could create confusion on the part of the retirees. Finally, plaintiffs have not proven that Equitable undertook a course of action in which it deliberately deceived plaintiffs about their health insurance, as the defendant had done in *Varity*. Rather, the evidence adduced at trial shows that Equitable went to great efforts to train benefits personnel and develop material that accurately described current benefits near or soon after the time of retirement.

For the reasons set about above, the court concludes that Equitable did not breach its ERISA fiduciary duty to plaintiffs.

Conclusion

Pursuant to the foregoing Findings of Fact and Conclusions of Law, the court enters judgment in favor of defendant The Equitable Life Assurance Society and against plaintiffs Delores Frahm, Royce Terry, Gerald Colson, Laurence Wilneff, Claire Goldberg, and Deborah Cooper on all counts of plaintiffs' complaint.

UNITED STATES CODE ANNOTATED
TITLE 29. LABOR
CHAPTER 18—EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B—REGULATORY PROVISIONS
PART 4—FIDUCIARY RESPONSIBILITY

§ 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

(2) In the case of an eligible individual account plan (as defined in section 1107(d)(3) of this title), the diversification requirement of paragraph (1)(C) and the prudence requirement (only to the extent that it requires diversification) of paragraph (1)(B) is not violated by acquisition or holding of qualifying employer real property or qualifying employer securities (as defined in section 1107(d)(4) and (5) of this title).

(Pub.L. 93-406, Title I, § 404, Sept. 2, 1974, 88 Stat. 877; Pub.L. 96-364, Title III, § 309, Sept. 26, 1980, 94 Stat. 1296; as amended Pub.L. 101-508, Title XII, § 12002(b)(1), (2)(A), Nov. 5, 1990, 104 Stat. 1388-565, 1388-566; Pub.L. 104-188, Title I, § 1421(d)(2), Aug. 20, 1996, 110 Stat. 1799.)

Supreme Court, U.S.
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No. 97-1915

IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

DELORES FRAHM, ROYCE TERRY, GERALD COLSON, LAWRENCE WILNEFF AND CLAIRE GOLDBERG, ON BEHALF OF A CLASS OF PERSONS SIMILARLY SITUATED,

Petitioners,

v.

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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No. 97-1915

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

DELORES FRAHM, ROYCE TERRY, GERALD COLSON, LAWRENCE WILNEFF AND CLAIRE GOLDBERG, ON BEHALF OF A CLASS OF PERSONS SIMILARLY SITUATED,

Petitioners,

v.

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF IN OPPOSITION

Statutory Provision Involved

As set forth by petitioners, other than certain jurisdictional statutes, the statutory provision involved in this case is Section 404(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1104(a), which is set out at petitioners' Appendix ("App.") at 39-40.

Counterstatement of the Case

This is a highly factual case, carefully evaluated and correctly decided by both the trial court that heard the evidence in a bench trial and the Court of Appeals that unanimously affirmed

the district court's thoughtful decision. Petitioners' Statement of the Case employs a selective and distorted statement of the facts to suggest that both courts found that The Equitable Life Assurance Society of the United States ("The Equitable") engaged in a concerted campaign of misrepresentations promising lifetime coverage for retiree medical benefits, but then held that the campaign did not violate The Equitable's fiduciary duty of care to participants in The Equitable's United States Employees, Managers and Agents Health Care Plan ("Plan"). Neither the evidence nor the decisions below are as described by petitioners.

Petitioners, retired insurance agents, alleged both individually and on behalf of a class that they were deprived of health benefits to which they were entitled as early retirees under the Plan. (App. 2, 15-16). More specifically, petitioners contested The Equitable's right to apply the terms of its amended health plan to them as retirees. (App. 2). As noted by the trial court and the Seventh Circuit, The Equitable's right to apply the amended health benefits program (the "CHOICE program") to retired insurance agents was set forth in the written plan instrument and the summary plan descriptions ("SPDs"), both of which expressly reserve the right to change the Plan's terms at any time. (App. 1, 16-18). Given the plain language of the Plan and the SPDs, petitioners did not appeal the trial court decision that The Equitable has a right under the Plan to apply the terms of the CHOICE program to them. (App. 2, 29).

Unable to prevail on a claim for benefits based on the terms of the Plan or the SPDs, petitioners pursued three theories—breach of bilateral contract, estoppel and breach of fiduciary duty—as the basis for their claimed entitlement to the pre-CHOICE health benefits. (App. 29). Each of these theories relied upon "misrepresentations" allegedly made to petitioners about the Plan. *(Id.)*. After carefully considering these theories, both the trial court and the Seventh Circuit rejected them as class claims and found that, as to the individual plaintiffs, the claims

had no merit. (App. 3-13, 29-38). Petitioners' claims were rejected in large part because the evidence established that petitioners were not misled at all, but rather, received letters which accurately described the plan at the time and which did not conflict with clear plan documents notifying participants that benefits could change at any time. (App. 6-10, 33, 37).

Comfortable that "The Equitable did not set out to deceive or disadvantage plan participants," the Seventh Circuit found that The Equitable did not breach its fiduciary duties. Based on the complete trial record, both the trial court and the Seventh Circuit found that none of petitioners' theories or evidence justified stripping The Equitable of its right to change the Plan. (App. 1-38).

Reasons Why The Petition Should Be Denied

I. Petitioners Mischaracterize The Seventh Circuit's Decision In *Frahm*.

Throughout their Petition, petitioners mischaracterize the Seventh Circuit decision. In their Statement of the Case, petitioners distort the factual findings of the trial court that were accepted by the Seventh Circuit, selectively highlighting facts that they believe support their assertion that The Equitable engaged in a concerted campaign of misstatements about retiree medical benefits. At the same time, petitioners conveniently ignore the ample evidence that The Equitable provided numerous written statements informing participants about the possibility of plan amendments, that the alleged misrepresentations were accurate at the time made and that The Equitable provided proper training to its benefits personnel. Similarly, petitioners' Reasons for Granting the Writ not only further distort the factual findings of trial court and the Seventh Circuit, but also grossly mischaracterize the legal conclusions of the Seventh Circuit.

Petitioners suggest that the Seventh Circuit rejected the principle that an ERISA fiduciary owes a duty of care to plan participants and beneficiaries in communicating with them about benefits. To the contrary, the Seventh Circuit explicitly recognized that principle and correctly applied the legal rule to the evidence.

A. Petitioners Mischaracterize The Factual Findings To Create The Appearance That The Equitable Engaged In A Concerted Campaign Of Misinformation About Retiree Medical Benefits.

Contrary to petitioners' assertion, this simply is not a case in which plan managers were allowed to drain the meaning from the disclosure requirements of ERISA through "capricious misstatements and misrepresentations." (Pet. at 15). Nor is this a case in which a "wide range of responsible individuals at Equitable acting as fiduciaries – from the president on down—said in concert that petitioners' health benefits would not change after their retirement." (Pet. at 9). In so asserting, petitioners blatantly ignore the evidence accepted and relied upon by the trial court and the Seventh Circuit in rejecting their claims.

Specifically, petitioners point to assurances purportedly made to them "before their retirement" to the effect that early retirement would "freeze" or "lock-up" the superior benefits of the pre-CHOICE health plan. (Pet. at 3-4). What the district court in fact found and the Court of Appeals affirmed is that letters to four of the six plaintiffs did *not* say that benefits were "locked in," one plaintiff received no letters at all and only one plaintiff received a letter referring to a "frozen" deductible. (App. 37). The district court found this evidence insufficient to prove a breach of fiduciary duty, and the Court of Appeals agreed.

Petitioners also fail to note that they were provided with written statements informing them of The Equitable's right to amend or modify the Plan at any time and instructing them to

review their Benefits Book, which contained a reservation-of-rights clause allowing amendments. (App. 22-29). In fact, many of the petitioners admitted at trial being aware of both the provision of the Plan that reserved The Equitable's right to amend or terminate plans and of prior changes made to retirees' benefits. (App. 23-29). Additionally, petitioners fail to reference a letter received by several of them well prior to their decisions to retire saying that The Equitable's decision not to apply the CHOICE plan to retired agents was "not cast in stone." (App. 33). Given that petitioners, who were experienced insurance agents, received SPDs and other writings warning them of The Equitable's right to change the Plan, petitioners' attempt to paint a portrait of themselves as uninformed plan participants who were duped into believing that their health benefits could not be changed after their retirement simply was not credible to the trial judge.

Equally disingenuous is petitioners' failure to disclose that both the trial court and Seventh Circuit ruled that the alleged misrepresentations about "lifetime" benefits and "frozen" costs were accurate statements at the time they were made. In fact, the district court found that "all of the letters upon which the petitioners rely were accurate descriptions of the health care plan as it existed at the time." (App. 33). The Seventh Circuit as well found that communications received were "technically accurate." (App. 8). Taken as a whole, the evidence credited by the trial court and the Seventh Circuit demonstrates an environment replete with written warnings about The Equitable's ability to modify the Plan. In explanation of this environment (and in another finding ignored by petitioners), both courts noted that The Equitable adequately trained its benefits staff to give correct advice. (App. 6, 37).

The list of key evidence accepted by the courts below and disregarded by petitioners in their Petition is disturbingly long—the unambiguous statements in the plan document, the SPDs and other writings warning that The Equitable could

modify or terminate the Plan; petitioners' pre-retirement knowledge of prior modifications to the Plan; petitioners' high level of experience with insurance documents and plans; the factual accuracy of the alleged misrepresentations; the timing of many of the alleged assurances after petitioners decided to retire; and The Equitable's successful efforts to train its benefits personnel. This evidence makes it obvious that this case involves nothing more than a fact-intensive analysis to determine whether the petitioners had a contractual right to fixed benefits. The courts below simply did not find that The Equitable had mismanaged or misrepresented its benefits plan. Accordingly, the factual record does not present an occasion for this Court to decide how ERISA remedies should apply to a proven breach of fiduciary duty.

B. Petitioners Grossly Misstate The Seventh Circuit's Legal Conclusions As Holding That ERISA's Duty Of Care Does Not Apply To A Fiduciary's Communications With Participants.

In their Question Presented, petitioners assert that this Court should grant certiorari to determine whether the Seventh Circuit erred when it held in *Frahm* that the fiduciary duty of care codified by ERISA Section 404(a)(1)(B) does not include a duty to convey complete and accurate information about plan benefits. (Pet. at i). The Seventh Circuit's decision in *Frahm* does *not* present this issue for review, because the Seventh Circuit *simply does not hold,* as petitioners claim, that "there is no duty of care that attaches to a fiduciary's communications with beneficiaries." (Pet. at 7). To the contrary, the Seventh Circuit's decision in *Frahm* acknowledges that ERISA Section 404(a)(1)(B) creates a duty of care and explains that a plan administrator satisfies that duty "by taking adequate precautions—such as training the benefits staff and providing accurate written explanations—even if the precautions sometimes prove to be insufficient." (App. 9). Read for what it says (not "translated"

to manufacture an issue), the Seventh Circuit's decision in Frahm in no way turns its back on the duty of care.[1]

In asserting that the Seventh Circuit found that the duty of care does not apply to communications with beneficiaries, petitioners not only misstate the holding of the Seventh Circuit, but attempt to hide their true complaint about the decision. Despite raising a different issue in their Question Presented, petitioners' later focus on the Seventh Circuit's reasonable admonition that ERISA Section 404(a)(1)(B) does not "create a standard of absolute liability." (App. 9). Explaining its reasoning for refusing to hold employers and plan administrators liable for statements by staff that failed to qualify their description of benefits with an explanation of possible changes in the future, the Seventh Circuit stated that:

> unless [ERISA Section 404(a)(1)] is a guarantor of accurate information at all times and for the indefinite future—unless it creates not only a duty of care, but also a duty of prevision—then claims that one or another bit of advice that was misleading do not violate this statute. (App. 8).

This comment is both common sense and good law. While petitioners would have this Court believe that the Seventh Circuit has turned a blind eye to false assurances about benefit plans, in truth the Seventh Circuit has emphasized that plan administrators must satisfy ERISA's duty of care. The Seventh Circuit found that The Equitable had satisfied this duty by taking "appropriate precautions—such as training the benefits staff and

[1]Instead, the decision is consistent with other Seventh Circuit decisions that acknowledge the availability of a cause of action for breach of the duty of care when fiduciaries affirmatively mislead plan participants or remain silent in circumstances when silence could be considered misleading. *See, e.g., Schmidt v. Sheet Metal Workers' Nat'l Pension Fund,* 128 F.3d 541, 546 (7th Cir. 1997), *cert. denied,* 118 S. Ct. 1513 (1998); *Anweiler v. American Elec. Power Service Corp.,* 3 F.3d 986, 991 (7th Cir. 1993).

providing accurate written explanations." (App. 9). What the Seventh Circuit wasn't willing to do was to hold such carefully administered plans liable when such precautions "sometimes prove to be insufficient." *(Id.)*. Contrary to petitioners' attempt to convince this Court otherwise, the Seventh Circuit's decision in *Frahm* does not hold that the duty of care fails to attach to communications with plan participants, nor does it reject the availability of a cause of action for breach of the fiduciary duty of care.

C. The Seventh Circuit's Decision in *Frahm* Does Not Depart From ERISA's Preference For Written Plan Documents.

In another distortion of the Seventh Circuit's holding in *Frahm,* petitioners assert that the Seventh Circuit erroneously suggests an inconsistency between ERISA's preference for written plans and a fiduciary duty to interpret and describe plan instruments carefully and truthfully. (Pet. at 15). The Seventh Circuit's analysis was quite clear and correct on this issue. Confirming the reasonableness of not allowing "oral variances from written plans," the Seventh Circuit pointed out the "havoc" that would ensue if plan sponsors were bound by the oral advice of benefits staff. As the Seventh Circuit so rationally stated: "We do not think that § 1104(a)(1)(B) takes back with the left hand the primacy of the written word that ERISA establishes with the right hand." (App. 10).

The alleged "inconsistency" of which petitioners complain is a red herring. Like countless other courts before it, the Seventh Circuit stressed the clear congressional purpose for requiring that ERISA plans be written. In that light, the Seventh Circuit emphasized that petitioners' claims based on oral advice must be rejected for fear of undermining that scheme. The Seventh Circuit did not vary existing law, nor did it hold that ERISA's

preference for a writing means that fiduciaries have no obligation to convey truthful information to beneficiaries.

II. The Seventh Circuit Did Not Adopt An Analysis Of ERISA That Conflicts With Decisions Of This Court.

Petitioners assert that the Seventh Circuit's decision in *Frahm* "adopted a crabbed analysis of ERISA that conflicts with relevant decisions of this Court" directing the lower courts to look to the common law of trusts to define the fiduciary duties of persons responsible for administering a plan. (Pet. at 12).[2]

Contrary to petitioners' assertion, the Seventh Circuit's decision in *Frahm* does not depart from the common law of trusts in refusing to adopt a standard of absolute liability for misleading communications with plan beneficiaries or participants. Under the common law of trusts, liability is not imposed upon a trustee for breaching his duties unless the trustee intentionally or negligently fails to perform his duties. *See* Restatement (Second) of Trusts § 201 comment a ("trustee does not commit a breach of trust if he does not intentionally or negligently do what he ought not to do or fail to do what he ought to do"). Petitioners cannot establish that the common law of trusts imposes the standard of strict liability they are asking this Court to adopt. Nor does this case present evidence of intent or negligence sufficient to constitute a breach of fiduciary duty even under trust law principles.

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[2]While not an issue that warrants addressing in this case, this Court has not, as petitioners claim, created an unbending rule that trust law principles be followed in ERISA cases. In fact, in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), this Court explained that courts must realize that some of the purposes of ERISA "require departing from common law trust requirements," such as the congressional "desire not to create a system so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans." *Id.* at 497.

III. There Is No Conflict Between The Circuits Over The Scope Of The Fiduciary Duty Of Care Owed To Participants And Beneficiaries Under ERISA.

Stretching to find grounds to justify their petition, petitioners fashion an argument that the Seventh Circuit's *Frahm* holding—which petitioners define as "there is no duty of care that attaches to a fiduciary's communications with beneficiaries"—conflicts with the majority of the other circuits. (Pet. at 7). Not only does the petition misstate the Seventh Circuit decision, the "conflict with seven other circuits" of which petitioners speak is nothing more than a figment of their imaginations.

The first fatal flaw in petitioners' argument lies in their tortured reading of the *Frahm* decision. As discussed above, the Seventh Circuit plainly did not hold in this case—nor has it held in any other case—that no duty of care attaches to plan administrators' communications with plan participants and beneficiaries. The second fatal flaw in this argument is that the decisions of the First, Second, Third, Eighth, Ninth, Tenth and District of Columbia Circuits, cited by petitioners as differing from the Seventh Circuit and other "minority circuits," (Pet. at 12), articulate a standard for an ERISA fiduciary's duties that is essentially the same as the decisions of the "minority circuits," defined by petitioners as the Fourth, Sixth and Seventh Circuits. In reality, *none* of these cases expresses as expansive a scope of the duty of care as that advocated by petitioners. Nor do any of *these* cases recognize any conflict in the law addressing fiduciaries' obligations under ERISA. In fact, each of the circuits relies on and incorporates the holdings of other circuits when addressing claims of a breach of ERISA's fiduciary duties. Notably, petitioners claim to have spotted a conflict not recognized by any Court of Appeals, including the Seventh Circuit panel in *Frahm*, and which petitioners never bothered to raise with the Court of Appeals in a petition for rehearing or rehearing en banc.

The gist of petitioners' argument is that other circuits have "found a fiduciary duty of care to provide complete and accurate information under ERISA § 404(a)(1)." (Pet. at 9). Petitioners argue that the Seventh Circuit, on the other hand, has "turned its back on the duty of care" (Pet. at 6) in conflict with these circuits. Petitioners' argument is based on their erroneous reading of the holding of *Frahm* and on misreading the holdings of petitioners' perceived majority and minority circuits. By latching on to *dicta* in the decisions of the First, Second, Third, Eighth, Ninth, Tenth and District of Columbia Circuits discussing plan fiduciaries' duties to provide accurate information to plan participants, petitioners imply that these decisions hold that a plan administrator will *always* be liable for providing any inaccurate or misleading information to plan participants. (Pet. at 9-11). Yet, none of these cases either expressly or implicitly advocates holding employers to the standard of strict liability that petitioners suggest.

To the contrary, the federal courts of appeals generally agree that employers breach their duty of care either by communicating false or misleading information to plan participants where the misleading statements are part of a widespread campaign to mislead participants or by engaging in gross negligence by failing to take steps to avoid misleading participants. For instance, the Third Circuit's decision in *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litig.*, 57 F.3d 1255 (3d Cir. 1995), *cert. denied sub nom. Unisys Corp. v. Pickering*, 517 U.S. 1103 (1996), which petitioners cite as a "notable instance" of a case that found a fiduciary duty of care to provide complete and accurate information under ERISA Section 404(a)(1), (Pet. at 9), was premised on the court's finding that the company "affirmatively and systematically" made misrepresentations in a climate of obvious confusion by participants. 57 F.3d at 1266. Indeed, in reaching its decision in *Frahm*, the lower court relied on, rather than departed from, the Third Circuit's *Unisys* decision, in finding that the

petitioners' claims did not reflect "affirmative and systematic" misrepresentations like those in *Unisys*. (App. 37). At the same time that the Third Circuit expressed a duty of care to communicate truthfully and accurately, like the Seventh Circuit in *Frahm*, it also recognized a "policy against informal plan modification." In *Unisys*, the court warned that its decision should not be utilized to undermine the rule that, under ERISA, neither oral statements nor informal documents can modify written plan terms. 57 F.3d at 1265.

Petitioners' reliance on the Second Circuit's decision in *Estate of Becker v. Eastman Kodak Co.*, 120 F.3d 5 (3d Cir. 1997), to further substantiate their claim of a split in the circuits is equally misplaced. (Pet. at 10). Petitioners describe *Becker* as a case in which the court found that a single inadequate response by a benefits counselor to inquiries about the terms of a retirement plan "violated the fiduciary duty to provide complete and accurate information." *(Id.)*. To the contrary, the Second Circuit expressly stated that its finding was based on the existence of both "materially misleading" information provided by the benefits counselor *and* deficiencies in the SPD provided to the beneficiaries. *Becker*, 120 F.3d at 10. Moreover, the Second Circuit refused to rule for plaintiffs without a showing that the misleading communication and the SPD actually caused plaintiff the harm alleged. *Id.* Thus, contrary to petitioners' characterization, the *Becker* decision does not reflect a conflicting position by the Second Circuit that a single materially misleading oral statement alone always rises to the level of a breach of fiduciary duty. Indeed, rather than conflict, this decision mirrors the Seventh Circuit's view of the importance of written plan documents, as well as its requirement that reliance on misleading statements must be shown to establish liability.

In the same vein, the decisions of the other five circuits that petitioners suggest articulate a standard of strict liability for inaccurate or misleading disclosures simply do not require any

different standard of care than the Seventh Circuit's decision. Neither the First Circuit's decision in *Vartanian v. Monsanto Co.*, 131 F.3d 264 (1st Cir. 1997), nor the Tenth Circuit's decision in *Maez v. Mountain States Tel. & Tel.*, 54 F.3d 1488 (10th Cir. 1995), suggests anything resembling a rule of strict liability for misleading or inaccurate disclosures to beneficiaries. In *Vartanian*, the First Circuit found that "lying" is inconsistent with the duty of loyalty owed by fiduciaries. 131 F.3d at 269-271. The Seventh Circuit's repeated distinction between the technically accurate statements in *Frahm* and the deception in *Varity* leads to the inescapable conclusion that, presented with the same circumstances as the court in *Vartanian*, the Seventh Circuit would reach the same holding. In the same fashion, the Tenth Circuit in *Maez* acknowledged the fiduciary duty of plan fiduciaries "not to affirmatively mislead plan participants." 54 F.3d at 1500. This is no different from the Seventh Circuit's holding in *Frahm*.

In the same vein, petitioners engage in a tortured reading of the Ninth Circuit's holding in *Barker v. American Mobil Power Corp.*, 64 F.3d 1397 (9th Cir. 1995), to suggest a split in the circuits. In that case, the Ninth Circuit relied upon the fiduciary's "affirmative misrepresentation" misleading the participants about the safekeeping of benefit funds. *Id.* at 1403. Again, an environment of affirmative misrepresentations—which the Seventh Circuit found absent in *Frahm*—led the Ninth Circuit, like other courts addressing similar circumstances, to find a breach of fiduciary duty under ERISA.

Equally inapposite is the Eighth Circuit's decision in *Shea v. Esensten*, 107 F.3d 625 (8th Cir.), *cert. denied*, 118 S. Ct. 297 (1997). Addressing a different fiduciary duty, namely ERISA's duty of loyalty, the Shea decision dealt not with allegedly misleading statements made to and relied upon by plan participants, but rather with the failure to disclose financial incentives that existed under the plan. 107 F.3d at 628-629. The Eighth Circuit said nothing different than the Seventh Circuit would have said in

similar circumstances—that when a plan administrator knows its silence regarding plan administration will be harmful, it has a duty to come forward and speak truthfully. *Id.* at 629.

The D.C. Circuit in *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747 (D.C. Cir. 1990), held comparably: when a plan administrator reasonably should have recognized a participant's special problem creating confusion as to coverage, it has a duty to inform him so as to alleviate his confusion. Nothing suggests that the Seventh Circuit would disagree. These simply were not the facts presented in *Frahm.*

In an effort to find a "minority" view (in addition to the Seventh Circuit), petitioners cite the Fourth Circuit's decision in *Faircloth v. Lundy Packing Co.*, 91 F.3d 648 (4th Cir. 1996), *cert. denied*, 117 S.Ct. 738 (1997) and the Sixth Circuit's decision in *Sprague v. General Motors Corp.*, 133 F.3d 388 (6th Cir.) *(en banc), cert. denied, mot. denied,* 141 L. Ed. 2d 170 (Jun. 8, 1998). Those decisions actually align with, rather than depart from, the holdings of the circuits characterized by petitioners as presenting a "majority" view. That is, they too hold fiduciaries liable for breach of their duties for affirmatively providing misleading or inaccurate information. *See Sprague,* 133 F.3d at 406 (noting that affirmatively providing misleading information may breach the fiduciary's duties to plan participants); *Faircloth,* 91 F.3d at 648 (acknowledging in dictum that an ERISA fiduciary may not mislead a participant or beneficiary).[3]

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[3]The petitioners' reliance on *Faircloth* is further flawed because that case did not allege misleading statements. Rather, it involved a fiduciary's failure to provide documents requested by participants to allow them to exercise an oversight role over the plan. *Faircloth,* 91 F.3d at 657. The court's analysis understandably focuses heavily on ERISA's disclosure requirements rather than on the issue suggested by petitioners as to the degree of misrepresentations necessary to establish liability. *Id.*

Rather than reflecting division among the circuits, the cases presented by petitioners show consistency among the circuits in holding ERISA fiduciaries liable where the evidence shows significant misrepresentations or misconduct. None of the cases cited by petitioners where plaintiffs prevailed presented the same circumstances as in *Frahm*, namely a well-trained benefits staff conscientiously trying to answer individual questions according to clear plan terms. Petitioners have not shown that any circuit has either intimated or expressed a breach of fiduciary duty for providing an accurate explanation of benefits but failing at every opportunity to predict future changes. Objective analysis of the cases cited by petitioners demonstrates that it is not the *legal* standard which varies in the cases cited by petitioners, but rather, the factual circumstances underlying each claim. All circuits agree that fiduciaries have a duty to communicate truthfully with plan participants. This Court need not address a conflict which does not exist.

IV. Petitioners Fail To Present Any Reason To Grant A Writ of Certiorari

Petitioners fail to present a single reason warranting further review of the Seventh Circuit's eminently reasonable, unanimous decision in *Frahm*. After a careful evaluation of written plan documents expressly reserving the right to modify the Plan, the training of the Equitable benefits staff, and the content and context of the alleged misrepresentations, the district court and the Seventh Circuit rationally concluded that The Equitable had not breached any fiduciary duty. In this context, a few contested statements about future benefit changes were insufficient in the courts' eyes to prove a breach of the fiduciary duty of care. At the same time, the Seventh Circuit stood firm in its recognition of the fiduciary obligation to communicate truthfully with plan participants. To promote that duty, the Seventh Circuit articulated

guidelines, stressing the importance of accurate written plan documents and adequate training of benefits personnel.

The Seventh Circuit's decision in *Frahm*, like the decisions of other circuits, specifically acknowledges the availability of a cause of action for a breach of the duty of care codified in ERISA Section 404(a)(1)(B) in appropriate circumstances. The Seventh Circuit's decision honors this Court's decision in *Varity* by insisting that statements deceiving and disadvantaging plan participants and beneficiaries not be tolerated. At the same time, the *Frahm* decision fosters the congressional dictate enacted in ERISA that plans not be subject to *ad hoc* oral interpretations, but rather, be administered according to written terms.

It is worth noting that this Court recently rejected a petition for writ of certiorari in a case presenting similar facts and legal theories. *Sprague v. General Motors Corp.*, 133 F.3d 388 (6th Cir.) (en banc), *cert. denied, mot. denied,* 141 L. Ed. 2d 170 (Jun. 8, 1998). As in this case, *Sprague* involved claims by early retirees challenging their employer's right to modify their health care benefits, despite their receipt of plan documents informing them that the company could modify or terminate its benefit plans. *Sprague,* 133 F.3d at 395. As here, the Sprague plaintiffs claimed that their employer breached its fiduciary duties to them by making certain statements—which the courts found to be true at the time made—about lifetime coverage. *Id.* at 405. In rejecting plaintiff's breach of fiduciary duty claims, the Sixth Circuit in *Sprague*, like the Seventh Circuit in *Frahm*, noted that there is no fiduciary duty to "disclose the possibility of a future change in benefits." Id. at 406 (emphasis in original). While the Sixth Circuit, like the Seventh Circuit in *Frahm*, recognized that a breach of fiduciary duty claim would result from a campaign of affirmatively misleading information about future plans, the Sixth Circuit found no such misconduct in the case before it. *Frahm* presents no additional basis, factually or legally, for a further review of this issue.

In sum, petitioners fail to articulate a legitimate conflict of law among the circuits regarding the scope of the ERISA fiduciary duty of care. The Seventh Circuit did *not*—as petitioners assert—find that the fiduciary duty of care codified in ERISA Section 404(a)(1)(B) does not include a duty to convey accurate information to plan participants. Instead, the Seventh Circuit's decision in *Frahm* carefully evaluated the facts presented to the trial court and applied a standard mirrored by other circuits to hold, correctly, that The Equitable did not breach its fiduciary duty to petitioners. Accordingly, the petition presents neither an example of a gross miscarriage of justice nor a legal issue ripe for further review and, therefore, the petition should be denied.

Conclusion

For the reasons set forth above, we respectfully submit that the petition should be denied.

Respectfully submitted,

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Respondent.

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Secondary Authority

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Wilber H. Boies, *New Focus for Erisa Litigation: Communicating with Employees about Benefits,* Practicing Law Institute, 26th Annual Institute on Employment Law (Sept. 1997) 9

Robert N. Eccles, *Fiduciary Litigation Under ERISA,* in *Pension Plan Investments: Confronting Today's Issues*, Practicing Law Institute, Tax Law and Practice (May 1998) 9

Dana M. Muir, *Truth or Consequences:* Varity v. Howe *and Beyond,* 13 Lab. Law. 411 (1998) 10

INTRODUCTION

In *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996), this Court held that a plan fiduciary violates a duty of loyalty under section 404(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1104(a), when it "participate[s] knowingly and significantly in deceiving a plan's beneficiaries in order to save the employer money at the beneficiaries' expense." Based on *Varity Corp.*, the circuits now agree that, at a minimum, under ERISA's duty of loyalty plan fiduciaries may not lie deliberately to beneficiaries and participants about their benefits. It is upon this baseline consensus that respondent, The Equitable Life Assurance Society of the United States ("Equitable"), rests its claim that the circuits now speak in one voice. But Equitable does not address the question left open by this Court in *Varity Corp.*, which now divides the courts and is presented by this petition: "whether ERISA fiduciaries have any fiduciary duty to disclose truthful information on their own initiative, or in response to employee inquires" under ERISA § 404(a)(1) (codified at 29 U.S.C. § 1104(a)(1)). *Varity Corp.*, 516 U.S. at 506.

This petition requests certiorari to resolve a circuit conflict over whether fiduciaries have a duty to disclose complete and accurate plan information in response to injuries by beneficiaries or participants under either section 404(a)(1)(A) or (B) of ERISA. Because the nation's ERISA plans should not be governed by a patchwork of legal duties varying from circuit to circuit, and because the ERISA duty to disclose should be enforced fully by all our courts, petitioners request that writ of certiorari be granted.

REASONS FOR GRANTING THE WRIT

A. THE PARTIES AGREE THAT ERISA PROVIDES A DUTY TO DISCLOSE COMPLETE AND ACCURATE PLAN INFORMATION

The parties agree on the basic principles underlying this case. Equitable does not contest that under conventional trust law standards (which undergird ERISA, *Varity Corp.*, 516 U.S. at 496), a fiduciary must furnish complete and accurate information about a trust upon inquiry by a beneficiary. (Pet. at 12-14.) *See* Restatement (Second) of Trusts § 173 ("[t]he trustee is under a duty to the beneficiary to give him upon his request at reasonable times complete and accurate information as to the nature and amount of the trust property . . . ."). Equitable even supplements petitioners' authority with its own citation (Resp. at 9) to Restatement (Second) of Trusts § 201, comment a, which confirms that a trustee should not be negligent in dealings with beneficiaries (a "trustee does not commit a breach of trust if he does not intentionally *or negligently* do what he ought not to do or fail to do what he ought to do") (emphasis added), and Equitable agrees at a minimum that *gross* negligence by a fiduciary in providing information would be actionable. (Resp. at 11.)[1] Nor does Equitable contest petitioners' premise that ERISA §404(a) incorporates the fiduciary duty to convey

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[1] While petitioners do not necessarily advocate that a negligence standard apply to review of fiduciary misstatements under section 404(a)(1) of ERISA, because a different standard of fault might be appropriate, we note that Equitable echoes our position *sotto voce* that the Seventh Circuit's interpretation of this section of ERISA—requiring deliberate misconduct by a fiduciary—imposes too low a burden on plan fiduciaries.

complete and accurate information about benefits. (Pet. at 12-15.)

What, then, divides the parties on this petition? Equitable argues first (at 4-8) that under the facts of this case, its employees received sufficiently complete and accurate information about the projected future of their health benefits. But the Seventh Circuit's decision precludes this line of argument. Reviewing the record below, the court of appeals found that Equitable's descriptions of the retiree's health benefits were "potentially misleading to someone who had a decision to make" and "did not (and could not) provide complete information about what would happen to benefits some years hence" (App. 8.) Equitable's analysis disregards this part of the Seventh Circuit's decision. It was *in spite* of these findings that the Seventh Circuit affirmed a judgment in respondent's favor. It did so by holding outright that a fiduciary who makes incorrect representations about the future of the health benefits to its employees would not be held liable unless the statements constituted, as the Seventh Circuit interpreted *Varity Corp.*, a "campaign of disinformation that led employees to surrender their benefits." (App. 6.) Excepting such deliberate misconduct, then, the Seventh Circuit holds that simple "[n]egligence—a violation of the duty of care—is not actionable." (App. 7.)

Equitable has also stressed that the district court found that Equitable satisfied its duty to provide complete and accurate information by "adequately train[ing] its benefits staff to give correct advice." (Resp. at 5.) But in view of the Seventh Circuit's holding that only deliberate misconduct is actionable under ERISA, the degree of care in training managers becomes less

meaningful. Under the *Frahm* rule, followed strictly, even the missteps of a poorly-trained staff would not necessarily trigger liability unless (for instance) the mistraining itself was a knowing act. As we note below, this stance is quite at odds with other circuits.

B. RESPONDENT UNDERSTATES THE DISCORD AMONG THE CIRCUITS

Petitioners have already chronicled (Pet. at 9-12) the split in the courts of appeals over the scope of the fiduciary duty to disclose complete and accurate information about benefits. Equitable papers over the difference between the cases (Resp. at 10-15) by arguing that the courts agree on a baseline duty of disclosure under ERISA, described variously as a duty not to engage in "a widespread campaign to *mislead*" participants (Resp. at 11), to refrain from "*affirmative* misrepresentations" (*id.* at 13), or to avoid "*affirmatively providing* misleading or inaccurate information" (*id.* at 14) (emphasis added). But Equitable—like the Seventh,[2] Fourth and Sixth

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[2] Equitable cites (at 7 n. 1) two other Seventh Circuit decisions, neither of which are controlling because of their distinctive factual settings. In *Schmidt v. Sheet Metal Workers' National Pension Fund,* 128 F.3d 541, 547 (7th Cir. 1997), the asserted misleading statement did not originate with a plan fiduciary, so the issue was not joined. Meanwhile, in *Anweiler v. American Electric Power Service Corp.*, 3 F.3d 986, 992 (7th Cir. 1993), the plan fiduciary violated its duty of loyalty by getting the participant to sign a reimbursement agreement that reduced the amount of his disability income, without explaining the effect of the agreement on his benefits, thereby "manipulat[ing] its position as insurer of the disability plan and life insurance policy to its own benefit rather than Mr. Anweiler's. . . ."

Circuits—would draw the line of ERISA liability at preventing *only* such deliberate misconduct, while finding no liability for other kinds of untruthful statements by fiduciaries. The Seventh Circuit held the duty in *Varity Corp.* extended only to such a case involving a "campaign of disinformation that led employees to surrender their benefits," while for other kinds of misstatements, no liability attached. (App. 7.) *See also Sprague v. General Motors Corp.*, 133 F.3d 388, 405 (6th Cir.) (*en banc*) (fiduciary duty delineated in *Varity Corp.* extended only to prohibit "deliberate misleading of employees"), *cert. denied*, 118 S. Ct. 2312 (1998); *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 657 (4th Cir. 1996) (except for prohibiting schemes to "mislead participants or beneficiaries," ERISA recognizes no "general fiduciary obligation under ERISA to provide information related to the plan on request"), *cert. denied*, 117 S. Ct. 738 (1997).

In contrast to these three courts, the majority of circuits find liability where there is untruthful, albeit not fraudulent, disclosure. (Pet. at 9-11.) To illustrate this point, let us pose this counterfactual inquiry: Could the plaintiffs from the majority-rule cases survive under the *Frahm* standard—that is, did those plaintiffs establish that the plan fiduciaries "bilk[ed] employees into surrendering their [benefits]" (App. 6)? We shall review a few key cases:

- In *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, 57 F.3d 1255 (3d Cir. 1995), *cert. denied*, 517 U.S. 1103 (1996), as in this case, the medical benefit plan expressly reserved the employer's right to terminate the plan "at any time," but the company informed employees that upon retire-

ment medical benefits would "be continued for the rest of your life." The Third Circuit affirmed a ruling that the company violated its duty by "misinform[ing] its employees about the duration of their benefits by stating over and over again, without qualification, that their benefits would continue for life." *Id.* at 1266. Equitable points to no material, factual difference between the *Unisys* case and the present one, yet the outcomes were polar opposites.

- In *Estate of Becker v. Eastman Kodak Co.*, 120 F.3d 5 (2d Cir. 1997) the employer neglected to inform an employee (Mrs. Becker) that her family would forfeit her pension benefits if she died before she retired. Because she was unaware of this fact, Becker (who by this time knew she was terminally ill) did not take other plan options available to her to safeguard her benefits. The Second Circuit found liability even in the absence of evidence that the company knew about the effect that its non-disclosure would have on Becker's family. In the absence of fraud or deliberate misconduct, Becker's family would have lost in the Seventh Circuit.

- In *Shea v. Esensten*, 107 F.3d 625, 628-29 (8th Cir.), *cert. denied*, 118 S. Ct. 738 (1997), the fiduciaries failed to disclose, under an HMO policy, that doctors had financial incentive not to make referrals to specialists. Again, in contrast to the Seventh Circuit, the Eighth Circuit imposed no requirement that the failure to disclose this information be deliberate, only that it be material.

- Finally, in a case decided since this petition was filed, *Farr v. U.S. West Communications, Inc.*, No. 96-36051, 1998 WL 310102 (9th Cir. June 15, 1998), the employer developed an early retirement plan, the "5 + 5 Program," which allowed employees to receive their accrued pension benefits in a lump sum. Along with a summary of the details of the plan, the employer published advice about the tax consequences of accepting the benefits. The published advice failed to mention a hitch in the tax law: that amounts exceeding the qualified portion of the lump sum eligible for tax-deferred treatment would be taxed immediately. The company included a disclaimer (in its summary plan description) that because tax options were "very complex" employees should consult a tax advisor. Despite the reservation, the Ninth Circuit reversed summary judgment for U.S. West and held as a matter of law that its actions breached a fiduciary duty to provide "*thorough and accurate* information explaining the 5 + 5 retirement option that it offered to entice employees to retire." *Id.* at *6 (emphasis added). In the Seventh Circuit, the absence of a deliberate campaign to mislead employees would have defeated this claim.

Thus, while the Seventh Circuit under *Frahm* (as well as the Fourth and Sixth Circuits, see Pet. at 11-12) requires lying, bilking or self-dealing by the fiduciary to state a claim, none of the circuits noted above (or in our petition) so required. The Seventh Circuit elided this conflict by citing none of these majority-rule cases on this issue—even in an attempt to distinguish them—

while instead citing the harmonious Sixth Circuit decision in *Sprague*. (App. 6.)[3]

Equitable repeatedly caricatures (Resp. at 9, 11 and 13) the ERISA duty to disclose complete and accurate information as a form of "absolute" or "strict" liability on fiduciaries for errors. (The same characterization appears in the court of appeals decision. App. 9.) Again, reviewing the case law from the majority of circuits, this is not the standard that petitioners seek or that imposed by the majority of courts. A beneficiary or participant would still have to prove (as they do in every circuit) at least that they suffered a harm caused by a fiduciary's nonfeasance, that the misstatement or omission was material to the beneficiary or participant and that ERISA provides a remedy. In addition, the trust law duty of care evinces a standard of reasonableness, which would go a long way to ease the burden postulated by the Seventh Circuit to avoid trivial or accidental misstatements.

But ours is not a case of a misplaced decimal point, or an unforecast financial catastrophe that levels a fund. It is an admitted case of numerous managers, even the president himself, promising health benefits without charge to employees—while apparently knowing (or fail-

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[3] Equitable also misapprehends (Resp. at 8-9) petitioners' argument that a fiduciary duty to convey complete and accurate information about plan benefits is a necessary complement to the duty to provide written plans and plan summaries (Pet. at 15). Participants and beneficiaries need to be able to trust fiduciaries to provide truthful answers to questions posed by plan documents, and an untruthful answer (even honestly given) can rob someone entirely of their benefits, such as in the majority-rule cases cited above.

ing to inform themselves) that the plan allowed the company to line out those benefits at any time. Telling the truth in this case did not require "prevision," as the Seventh Circuit put it (App. 8), but simply telling employees (consistent with the summary plan description) that retiree benefits could be changed or eliminated at management's discretion. The bottom line question presented by these cases is who bears the cost when the plan fiduciary (like the trustee at common law), charged with keeping the beneficiaries and participants informed, speaks untruthfully? It is a question worthy of this Court's review.[4]

Commentators concur that courts are divided on this important issue. *See, e.g.*, Wilber H. Boies, *New Focus for Erisa Litigation: Communicating with Employees about Benefits*, Practicing Law Institute, 26th Annual Institute on Employment Law at 683-704 (Sept. 1997) (outlining the cases and observing that, on this issue, "the law varies among the circuits"); Robert N. Eccles, *Fiduciary Litigation Under ERISA*, in *Pension Plan Investments: Confronting Today's Issues*, Practicing Law Institute, Tax Law and Practice at 32 (May 1998) (observing that a "growing amount of litigation alleging section 404(a)(1)(A) violations has focused on allegations that participants were promised a benefit which is not, in fact, provided under the express terms of the plan,"

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[4] Equitable regards it "worth noting" the Court's recent denial of certiorari in *Sprague v. General Motors Corp.*, 133 F.3d 388 (6th Cir.) (*en banc*), *cert. denied*, 118 S. Ct. 2312 (1998), which also presented a fiduciary duty claim. (Resp. at 16.) Yet the petitioners in *Sprague* did not raise the fiduciary duty issue in their questions presented to this Court (see 66 U.S.L.W. 3709 (1998)), while petitioners make this the sole focus of their case.

and noting split among the courts on this issue); Dana M. Muir, *Truth or Consequences:* Varity v. Howe *and Beyond*, 13 Lab. Law. 411, 422 (1998) (while the circuits "agree that a fiduciary's affirmative material misrepresentations" may constitute a breach of fiduciary duty, they disagree on the scope of the duty beyond that point). (These articles all appear in Westlaw's TP-ALL file.)

It is not possible to accept Equitable's sanguine view of the state of the law. The split of authority is both genuine and yawning. Only this Court can bring order to the chaos.

CONCLUSION

Petitioners pray that the petition for writ of certiorari be granted.

Respectfully submitted,

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